

WORKING IN A STORIED WAY.

THE DEVELOPMENT AND EVALUATION OF
A NARRATIVE BASED APPROACH TO
PRACTICE DEVELOPMENT IN AN OLDER
ADULT RESIDENTIAL CARE SETTING.

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Abstract

This thesis presents the development, implementation and evaluation of a methodological framework for a narrative based approach to practice development and person-centred care in residential aged care settings. The study is underpinned by practice development, person-centred care and narrative methodologies. Narrative focuses on a way of being, paying attention to past present and future, and also as a way of doing, as the means through which action is understood and made meaningful. Carried out between 2010 and 2014 and underpinned by theories of narrative inquiry, person-centred care, practice development and action research, this study is guided by the philosophical perspectives of Heidegger (1962).

Forty six interviews, collected as part of a national research programme, (Person-Centred Care Practice Development Programme 2007-2010), were analysed for key themes by myself, four focus groups of 12 clinical nurse managers and two independent experts. Themes were also derived from a focus group of eight residents who explored person-centredness and narrative. Combined, this analyses led to a single set of themes that were used to develop a Framework of Narrative Practice. This framework consists of four pillars, prerequisites, care processes, care environment and narrative aspects of care. The framework further includes three narrative operational elements, narrative knowing, narrative being and narrative doing. Working with the four foundational pillars and the three narrative elements enabled staff to 'work in a storied way' and provide person-centred outcomes and a narrative informed philosophy of care for older adults.

Using an action research approach with work-based learning groups, the framework was implemented in two residential care settings that were comprised of 37 residents and 38 staff. Three action cycles (1) narrative practice and culture identification, (2) developing narrative practice and (3) working in a storied way emerged during the implementation. Using these action cycles, staff developed action plans to address areas where changes could improve practice and quality of life for the residents. These plans included communication/intercommunication, homely environment, having more going on with and for the residents and meals and mealtimes.

By taking account of their biography, the framework confirmed the identity of older people. Three key areas emerged, however, that warranted further conceptualisation. These were, how staff and residents responded to change (narrative being), development of shared understandings (narrative knowing) and intentional action (narrative doing).

Key words: Narrative, Person-centredness, Practice Development, Participatory action research, Older people, Framework, Implementation, Residential care.

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Molly's Tale

This is my story
What does it mean
Do you care that I climbed mountains.
Or that I had dreams

to one day be famous,
an author or accountant.

You know me as Molly
A mother and a wife
but that is not the sum total of my life...
My dreams they were vast and some even came true.

This matters to me
Does it matter to you?

I sometimes feel angry
That you do not realise
I climbed Kilimanjaro when I was 35.
I wrote a novel in my 20s and I have 2 degrees.

This is the essence
of who it is to be me.

So I sit here in this nursing home
And my intellect declines
Because no one engages in a way that defines
The me I want to be, the person I am.

The one with the accolades,
the parchments and bad hands.

Bad hands from working in a bakery
from sixteen to twenty four
but you didn't know that did you
as you came to my door.

You're pleasant enough
I cannot deny
But our conversation is superficial,
very American pie.

"Good day" "How are you"
"I hope you are well"
Do you really care... I cannot tell.

I long for more substance,
to have a real voice.
To be considered in decisions
regarding my life.

I want to contribute,
I have some ideas
I was really quite something
before I came here.

So please do include me
and let me take part.
Ask my opinion
it will be a start.

Debate and consensus
make everything clear
When you work in this way
it really shows that you care.

Catherine Buckley 2014 (C)

Chapter 1 Introduction to the Thesis

Introduction

In this chapter, I will outline the background to this study and will discuss both my personal journey and reasons for undertaking this approach. I will outline the work this study is built on and will briefly describe both person-centredness and narrative. The chapter will conclude with a description of the thesis structure.

People who are over 65 years of age and who are defined by the Central Statistics Office (CSO) as older people make up 11.8% of the population in the Republic of Ireland (CSO 2007). The CSO predicted that between 2006 and 2036 the number of older people will increase by 77% and the older old, those defined as over 80, will double (CSO 2007). Currently, 6% of older adults reside in residential care in Ireland, which is in line with the European average (CSO 2012).

In 2006, the National Council on Aging and Older People (NCAOP) conducted a study on "Improving Quality of Life for Older People in Long-stay Care Settings in Ireland". The researchers identified that residents in long-term care should be allowed to develop both physiologically and psychosocially and that person-centred and individualised care was essential for the resident to have a good quality of life (Murphy, O' Shea, Cooney, Sheils and Hodgins 2006). One of the domains of quality of life that emerged from the study was 'personal identity' (Murphy et al. 2006 p.4). Personal identity was defined as "a resident's ability to maintain his/her personal identity or sense of self" (Murphy et al. 2006 p.4). Personal identity defines each resident as unique with individualised life experiences. Acknowledgement of a long-term care residents' personal identity is dependent on how the care that individual receives is shaped around their complete life history.

Improved treatment for diseases has led to an increasingly frail and older population (O'Neill 2006). This coupled with a lack of carers or carers who themselves are older adults, means that residential long-term care continues to play an important role in health care services provision in Ireland (An Bord Altranais, 2009). Increasing regulation internationally and the need to provide services that are driven by a quality agenda have prompted the need for services that are based on best practice evidence, continuously improve quality and are service user driven (U.S

General Accounting Office 1999, Department of Health 2001b, Department of Health and Children 2003). In the US, recent research has focused on quality improvement initiatives and their association with organisational culture change in residential long term care (Berlowitz Young, Hicky, Saliba, Mittman, Czarnowski, Anderson, Ash, Rubenstein and Moskowitz 2003). In Australia, national standards and monitoring systems for nursing homes have formed the basis for quality improvement (Bartlett & Boldy 2001). Similarly, in Ireland both the National Standards for Residential Care Settings (Health Information Quality Authority [HIQA] 2007) and the An Bord Altranais,[ABA] (2009) Professional Guidance for Nurses Working with Older People have been established to promote high quality care.

Personal Journey

In the late 1980s, like many others, I took the 'immigration train' to the USA in search of work. Leaving Ireland as a newly qualified nurse, I had idealistic aspirations that as a staff nurse I was going to influence change. This naivety was in no way influenced by my training, which did not in anyway encourage me to believe that nurses could influence change or even be part of it. That is, I was trained in the apprenticeship model where students and junior members of staff were very much non entities on the ward and were only valued for their ability to be 'good workers' who 'did' and never questioned. I became the good worker and throughout my training rarely if ever questioned practices that were either dictatorial or sometimes cruel. Ward sisters controlled the behaviour/practice of staff nurses who in turn ensured that students toed the line. Senior students were tasked with maintaining compliance within the student ranks; this often led to new students being ostracised by their student counterparts. My training did not prepare me for working in the USA where my opinion was sought and valued not only by colleagues, but also by doctors. I came to value a system where nurses were asked what they thought and where nurses' ideas and contributions actually influenced patient care and quality of practice. During my time in the USA I worked on an acute care of the older adult ward. Patients on this ward were seen as the consumers of healthcare and staff were considered the deliverers of that service. In addition, patients were encouraged to question medical and nursing decisions, care was planned with input from patients and their families, and care decisions were planned with respect to the life of the patient. Upon my return to Ireland to work in long-term care of the older adult, 10 years later, it was with horror I discovered

nothing much had changed. Hierarchical management structures were still in place, nurses were still the handmaiden of the doctor and residents were considered 'lucky' to have obtained a place in the long-term care facility. Care in Ireland was routinised with practices such as bowel books and shower/bath schedules. Having come from a culture of openness to one that demanded conformity, I found it difficult to settle and often found that I was challenging decisions and practices that were task orientated or medically driven. I am sad to say, however, that in the long run it was easier to say nothing and to conform than to challenge. For many years, I worked in this oppressed culture trying in some small way to influence the care received by these older people while covertly undermining some of the poor practices that were occurring .

After completing a BSc in Nursing and during the completion of an MSc., (an endeavour that was not usual in the setting, higher education of staff was not valued), I had an opportunity to work in practice development. I saw this opportunity as a way I could influence care and care practices. At this time some practices were slowly changing and staff were coming to realise that certain aspects of their care delivery were not acceptable. However, change was slow and was often hampered by an organisational culture mentality of “we’ve always done it that way”.

In the period 2007 to 2009, a research group led by nurse researchers from the University of Ulster (Professor Brendan McCormack and Dr Jan Dewing) conducted a collaborative practice development programme. This programme focused on a number of cooperative inquiry methods (Heron & Reason 2008) including consumer narrative interviews (Hsu & McCormack 2010). The researchers explored the processes involved in establishing person-centred care, in reporting outcome measurement and in conducting process evaluation of older person care settings in the Republic of Ireland (McCormack, Dewing, Breslin, Tobin, Manning, Coyne-Nevin and Kennedy 2010). It was hoped that these processes would inform the improvement of residential care in a more effective and person-centred way as outlined in the Health Strategy (Department of Health and Children, [DOHC] 2001a), the Health Services Reform Programme (DoHC 2003), the National Standards for Residential Care Settings (Health Information Quality Authority, [HIQA] 2007), and the Professional Guidance for Nurses Working with Older People (An Bord Altranais [ABA] 2009).

The facility where I was working was chosen as one of the pilot sites for the implementation of the National Person-Centred Care Practice Development Programme in 2007. This programme focused on changing the culture from within the organisation and from the bottom up, involving all grades of staff. At the heart of the programme was recognising the beliefs and values of both the older adults and staff, and utilising these values to develop a shared vision. A vision that was common to both the staff and the residents (McCormack et al 2010). The research undertaken in this doctoral study builds on the work commenced in the National Programme and contextualises person-centredness and narrative based approaches.

Person-centredness

Person-centred care (PCC) is a concept that is widely used in both nursing literature and nursing research. It purports to represent measurable and effective patient care, however in practice few nurses can demonstrate if their practice is in fact person centred (O'Donovan 2007). There is no one specific definition of person-centred care and in fact it can mean different things to different people in different care settings (Gillespie, Florin & Gillam 2004). Definitions of person-centred care broadly follow the same outline of promoting patient involvement in healthcare and enforcing positive engagement, which in turn will produce better patient outcomes. (Johns 1994, Kitwood 1997, Binnie & Titchen 1999, Barker 2000, McCormack 2003, Nolan, Davis, Brown, Keady, & Nolan 2004, McCormack & McCance 2006). The concept of person-centred care is underpinned by an existentialist philosophy of nursing that sees each person as a unique individual with their own beliefs and values (McCormack & Titchen 2006). Person-centred care proposes to promote an enabling relationship between the nurse and the patient (McCormack 2003).

In a literature review to determine if there was justification for the use of different types of centredness and if centredness itself as a concept was important, Hughes, Bamford and May (2008) identified five types of centredness: patient, person, client, family and relationship. All of these types of centredness have been mentioned and promoted in the healthcare literature since the 1990s (Kitwood 1997, Michie, Miles & Weinman 2003, McCormack 2004, Nolan et al. 2004, Sheilds Prat & Hunter 2006, Patterson 2008). Hughes et al. (2008) determined that the types of centredness

were largely the same, but that their difference is determined in their application. They believed the importance of centredness is demonstrated by encouraging practitioners to move from a biomedical model of care to a model exemplifying the relevance of interactions with others and acknowledging the impact of these interactions on both social and psychosocial aspects of care.

There are a variety of definitions that have been used to describe person-centred care. For example, person-centred care has been described as the relationship that exists between nurses and the people they are caring for (Webster 2004). It has also been described as the way care is delivered (Ford & McCormack 2000). It is the variation in definitions of person-centred care that often make it difficult for nurses to determine what is being talked about. Person-centred assessment, person-centred practice, compassionate practice and relationship centred care all ascribe to define person-centred care and its application by nurses practicing in care settings. These interchangeable and sometimes conflicting definitions often make it difficult for nurses to fully define and describe how they practice (McCormack et al 2010).

While the published literature shows a lack of consistency in description and a lack of clarity in definition of person-centred care, Slater (2006) attempted to define the concept of person-centred care by taking into account the different definitions and the recurring themes underpinning it. According to Slater (2006), central to all the data analysed was putting the person at the centre of the care provision. Slater uncovered greater than 500 articles using her search term; those articles that did not have a definition or did not help with the analysis of the concept were rejected. She does not report the final number of included articles in her concept analysis. In her analysis, Slater used dictionary definitions to describe the terms patient, person and client and stated that the inclusion of both client and patient changes the idea of what person-centred means. However if person is the focus of care, regardless of the term used to describe them, then it can be argued that that is person-centredness. While Slater (2006) acknowledges that several authors use terms such as patient, client and person interchangeably and emphasizes that many attributes of person-centredness are relevant to patient care she further concedes that the balance of power in these relationships often rests with the carer. This is in

line with my own personal experience as outlined earlier, where residents were considered lucky to be obtaining care and staff felt they should be thankful.

Confusion with the concept of person-centredness, as suggested by Slater, is attributed to the work of Nolan et al (2004). Whereas other models focus on the person and making the person central to the care provision, the framework by Nolan et al, relationship centred care, focuses on the relationship between the patient/family and the nurse and Nolan states this should be central. In fact, Nolan et al (2004) believed that person-centred care is generally too focused on the patient and not on the wider context in which the patient is cared for. While Slater (2006) suggested the concept is distorted by the different terminologies used and that this can have a harmful impact on how nurses perceive person-centredness she does state that if person-centredness is attained the result is improved outcomes for the person. She further acknowledged that true person-centredness also leads to better interaction between the healthcare team, patient and family. Slater (2006) stated that several other authors have described attributes of person-centredness but have not actually defined it as a concept. This may be because as Slater in her own attempt has found, person-centredness is a nebulous concept that is difficult to define. This will be elaborated on in Chapter 4.

What is Narrative?

Narrative comes from the Latin verbs *narrae* and *gnarus* which mean to recount and knowing or skilled. So therefore a narrative is a skilled recounting of an event. Narrative has been used in studies as both an underpinning philosophy and as a methodology. Narrative has been described as a way of being with others, being able to understand and to identify with the individual in an empathetic way (Kleinman 1988) and as a way of doing, ensuring that all activity is meaningful and based on reflection and action (Polkinghorne 1998 p.135). This aspect of narrative will be discussed in greater detail in Chapter 4. Personal narratives have importance for aesthetic knowing and for use in qualitative research, as they provide rich data on lived experiences. There has been much debate in the literature over the interchangeable use of narrative and story. Some researchers (Bluck & Habermas 2000, Kelly & Howie 2007, Hyden & Orluv 2008) believed that narrative and story are synonymous and that a person's life story is their narrative. Others such as Paley and Eva (2005) believed that 'while all stories count as narratives not

all narratives count as stories'. They described narratives as containing many steps that are interwoven and dependant on one another. The furthest step in this continuum is story which is the total drawing together of all the steps to form a whole plot. Frid, Ohlen and Bergbom (2000) echoed this and further prescribed that the narrative must have unity and each part of the narrative must contribute in some way to the outcome. Personal narrative can provide insights into what is unique about a person (Paley & Eva 2005) and give a deeper understanding of the event being described. The interchangeability of story and narrative becomes further complicated when narrative is used as a method of research. Narrative research has been described as the study of life events, stories or accounts of actions (Clandinin 2007) and has been used in past research to explicate lives and value human experience (Clandinin & Connelly 2000). Narrative research and narratology, which is the study of narrative and narrative structure, a term first coined by Todorov in 1969 (Prince 1982), will be dealt with in more depth in the philosophical underpinnings of this study Chapter 4. Narrative as an approach and the use of narratives may not be appealing for all people and is likely to require time and effort, the development of trust and opportunities to build relationships. All of these issues will be dealt with throughout the study.

The study of narrative includes four approaches, these are temporal (Ricour 1991) causal (Reismann 1993), minimal (Labov 1982) and transactional (Bruner 2004). The narrative event must be situated in time (temporal). There must be a connection (causal) between the events. The statement or mention of an event (miminal), the way a text is read or communicated between two or more people, or a personal interaction (transactional) are all components of narrative. It can be further defined as:

"a sense of statements that deal with a causually related sequence of events that concern human (or human like) beings" (Cohen 1999)

Or

"The representation of at least 2 real or fictive events in a time sequence" (Prince 1982).

If a narrative does not possess causal ties it is merely a sequence of events. Richardson (2000) believed that narratives, either verbal or non verbal (such as painting dance etc.) must have a causal connection. He further stated that contrary

to post structuralist beliefs, the historical development of narrative theory cannot be engulfed into one 'Master Theory'. The story of modern narrative is best told by grouping competing ideals of how narrative has developed rather than trying to pack everything neatly into one single philosophy. While data can be garnered to support any one theory of narratology, the advantage of narrative is a construction of the individual's own life history. Despite narrative being informed by theory, the construction of one's life history prevents it from fitting neatly into any one philosophy. For example, modern narrative theory is a combination of several different approaches rather than one single comprehensive approach (Richardson 2000).

Some researchers Paley & Eva (2005) and Frid et al. (2000) believed that narrative and story should not be used interchangeably. However, other researchers, (Denzin 1989, Bluck & Habermas 2000, Kelly & Howie 2007, Phoenix & Sparkes 2007, Hyden & Orulv 2009), all claimed that story and narrative are synonymous. Taking into consideration these inconsistent reportings, as well as, practitioners interchangeable use of the terms, I considered story and narrative as synonymous and used interchangeably in this study. This will be further discussed in Chapter 3.

Background

Services for older people in Ireland: an historical perspective.

Services for older people in Ireland have evolved slowly over the last 100 years. In the early 1900s social care for older adults was neither well recognised nor well governed. Irish people tended to look after their older people at home and felt that being admitted to long-term care was tantamount to accepting charity (Barrington 2000). Family support systems were strong, often with the mother/wife of the house remaining at home, which facilitated the caring role (Harvey 2007). Older adults who required care were mostly housed in work houses or asylums for the insane that were run by religious orders or voluntary organisations (O' Cinneide 1999).

The early 1920s, after the civil war, saw new social welfare structures put in place with the emergence of the new Free State Government (Barrington 2000). Increasing poverty and the high prevalence of immigration, however, led to old infirm people being admitted to county hospitals or welfare homes. Older people with dementia or mental infirmity were often admitted to mental asylums (Harvey 2007).

All of these institutions were seen in a negative light by the majority of the population and were known locally by such names as the County Home, the Ward or the Union (Acheson, Harvey & Keeney 2004). This local naming has followed these institutions into modern day society and sometimes has led to a sense of shame for older adults who are admitted to residential care settings. At this time, the Catholic church was very influential in service provision for older people and indeed in the health service in general and it exerted power and authority over the people utilising these services (O'Brien 2009).

In 1947, new Irish government structures were established and the Department of Health was formed. While this department had responsibility for the running of the health services, County Homes and Welfare Hospitals were still run by local authorities (Harvey 2007). It was not until 1970, when the Government initiated the Health Act, that the running and administration of healthcare became the remit of the eight newly established health boards (Wren 2003). During the 70s and 80s, services were run on an ad hoc basis with little or no policies in place. Existing policies tended to centre mainly on issues relating to organisational structures (O'Shea 2009).

Services for older people in Ireland: Contemporary perspectives.

In 1994, the Department of Health issued a policy document entitled "Shaping a Healthier Future: A Strategy for Effective Healthcare in the 1990s". This policy was based on three basic principles 'equity, quality of service and accountability' and was underpinned by recommendations from "The Years Ahead – A Policy for the Elderly" (DOHC 1998) and by the Health (Nursing Homes) Act 1990 (O'Shea 2009). The policy placed an onus on health boards to take ownership of reaching agreed targets (O'Shea 2009). For services aimed at the older adult, this policy supported older adults being maintained at home through strengthened community services. For those older persons no longer able to live independently, an increase in places in long stay residential settings was established (Department of Health and Children [DOHC] 1994).

In 2001, the DOHC issued a new policy document which outlined a ten year plan for healthcare reform. The strategy "Quality and Fairness: A Health System for You" (DOHC 2001b) added a fourth principle to the earlier Shaping a Healthier Future document; services should be people-centred. This was the first occasion that

personhood or people centredness was featured in any policy document of the Department of Health and Children. For older adults, this policy outlined (a) action points that offered a more integrated service, (b) increased funding for voluntary and community bodies, (c) implementation of the Health Promotion Strategy “Adding years to life and life to years” (DOHC 1998) and (d) increased services for people with dementia (DOHC 2001a).

The need to provide improved quality of patient care in a more profitable and patient-centred way was outlined in the Health Services Reform Programme (DOHC 2003) and the Health Services Executive (HSE) transformation Programme (HSE 2007). These programmes, along with the well-publicised case of a period of three years where a high number of deaths occurred in Leas Cross, a private nursing home, led to an Amendment to the Health Act (2004) and the establishment of the Health Information Quality Authority (HIQA). HIQA is a statutory body that has regulatory and inspectorate power over all public and private older adult residential facilities in Ireland (HIQA 2007). HIQA established a set of residential care standards that all older adult residential care settings must adhere (HIQA 2007). Underpinning both the legislation and the standards is the premise that care for older adults in residential care settings must be holistic and person centred. Collectively, the DOHC is responsible for strategic policy and planning analysis, the HSE has responsibility for management and delivery of services and HIQA is responsible for the provision of information and quality leadership. HIQA also has responsibility for setting standards at clinical and managerial levels and for assessing whether these standards are achieving the best possible outcomes using available resources (DOHC 2003).

Tester, Hubbard, Downes, McDonald & Murphy (2004) and Murphy et al. (2006) identified four core domains of quality of life that are important to older adults living in residential care. In a qualitative descriptive study, Murphy, O’Shea and Cooney (2008) using 7 focus groups with 67 nurse manager participants identified factors that influenced the quality of life of older residents in residential care and factors that influence policy. Key areas highlighted were “physical environment, making it like home, involving the family, the social environment, meaningful recreational activities and community connections” (Murphy et al. 2008). A need for the development of a

Bill of Rights for older people was identified as a key policy issue that would help to drive the quality agenda.

Murphy (2007), in a mixed method study, to determine the factors that facilitate or hinder high quality nursing care in residential care settings, found that a homelike person-centred multi-disciplinary environment that promoted autonomy and independence, that employed staff who were clinically knowledgeable and knew the residents, supported the delivery of a quality service. She also found that quality was hindered by the opposition of staff to change, lack of choice, time constraints and a task orientated routinised care environment. Murphy's instrument, a self completion questionnaire designed by the researcher based on interviews and literature, was not validated prior to its use in this study which could have led to questions about its validity and the subsequent results of the study. However, studies by Murphy et al. (2008) and O'Connor & Murphy (2009) have supported these results.

Conclusion

Residential care for older people provides personal and social care for people who are no longer able to live in their own homes (Szczepura, Clay, Hyde, Nelson & Wild 2008). Increasingly both nationally and internationally, this is occurring in an environment that is subject to regulation. Residential services have moved away from secular control to control by the state and this has led to more accountability and regulation. While several policy documents in Ireland have attempted to address how care should be shaped, it was not until 2001 that the Department of Health and Children acknowledged person centredness as key to its strategy for healthcare reform. The regulation of residential care settings has led to improvement in services, with increased quality of life and improvement in key quality indicators for residents. Providing services for older adults that are person centred provides a challenge for staff. The use of narrative and recognition of biography can lead to a co-constructed plan of care that promotes interaction between the resident and the staff and acknowledges the importance of the life experience of the older adult.

The impetus for the present study stems from both my personal involvement in the National Person-centred Care practice development programme (McCormack et al.

2010), as an internal facilitator and my background as a practice development facilitator. During the National programme it became evident that the life experiences of residents in long term care were not taken into account when planning or developing care. Additional impetuses were provided by the lack of understanding among staff regarding the importance of life history and the absence of a suitable framework for nurses to utilise when obtaining this information for planning care. In this study, I aim to both develop and evaluate a methodological framework to extend a narrative based approach to practice development and person-centred care in residential aged care settings. The primary purpose of this research is to implement a narrative based approach to help nurses operationalise person-centred care.

Thesis Structure

The thesis is presented in a series of chapters that are outlined as follows. This chapter outlined the background to the study and I described both the historical and policy led development of residential care services in Ireland. This chapter also illustrated the increasing emphasis on regulatory requirements and the drive to measure care against these regulatory standards. The influence of person-centredness is evident in this chapter both in policy and regulatory development and within my own personal journey and professional development.

Chapter two will discuss the literature on the evolution of care for older people, nationally and internationally, focusing on the development of models of care, the influence of person-centredness and the culture change movement.

Chapter three discusses literature relating to narrative and its concepts, person-centred care and practice development. It will critically review the literature supporting and contradicting narrative use as both a healthcare intervention and as a method of analysis of healthcare needs. It will also look at the use of narratives in both reminiscence and person-centred care.

Chapter four focuses on the philosophical and theoretical underpinnings of the study. It will outline the linkages between narrative, practice development and person-centredness. Key texts and the underlying philosophy of these three

elements will be discussed and a case for the use of narrative as the overarching paradigm will be made.

In Chapter five action research, as the chosen research methodology to underpin the study, will be explicated. The origins, definitions and approaches along with the advantages and disadvantages and ethical principles of the action research will be discussed. The place of narrative inquiry in action research will also be examined. In this chapter, phase 1 of the research cycle, the data analysis and the approach undertaken in secondary data analysis of existing interviews will be explained. The development of the methodological framework and its foundational and operational elements will be outlined.

Chapter six will provide an overview of data collection methods. It will outline the approaches undertaken in the implementation and evaluation of the framework in practice. It will briefly outline issues arising in the study, work-based learning activities undertaken and provide an outline of data collection methods.

Chapter seven will focus on the story of the implementation of the framework in practice. This chapter will discuss the approach employed with the work-based learning groups and the development of action research cycles. It will use a case study approach under three headings, (1) narrative practice and culture identification, (2) developing narrative ways of working and (3) working in a storied way.

Chapter eight presents the results of both the ongoing evaluation of the project and the overarching evaluation. The evaluation will be outlined in terms of both the documentary analysis that occurred at midpoint and end of study, and also with regard to the data that were collected on the programme days and in the work-based learning activities.

Chapter nine will discuss the findings in relation to the three elements of narrative, being, knowing and doing. As well, the finding of how people respond to change, the development of shared understanding and intentional action will be shared. This chapter will also discuss both the limitations of the study, implications for practice, implications for further research and contributions to knowledge.

Chapter 10 presents a personal story of self reflection on the research process. It will outline my own reflections on the research process and the approaches undertaken and concludes the thesis.

Chapter 2: The Evolution of Care in Older Adult Residential Care Settings

Introduction

In this chapter I will discuss the evolution of care in residential care settings taking account of person-centred approaches, models of care and the culture change movement.

In developing this review, the databases CINAHL, PUBMED AND PSYCH INFO were searched using the keywords - older adult, residential care, healthcare, long-term care, person-centred, relationship centred, models of care, practice development, organisational systems and culture change. Google Scholar and manual searches of books and journal citation lists were also undertaken. The search terms and limits used in this comprehensive search are outlined in Appendix 1.

Internationally, public policy has driven the need for residential long-term care to provide a service that is based on best practice, quality improvement models and management systems, that take account of the values and beliefs of residents and staff and that promotes their well-being (U.S General Accounting Office 1999, Department of Health 2002, Department of Health and Children 2003). This consideration has occurred against an environment of increased regulation, emphasis on quality assurance worldwide and a recognition that models of care need to take account of the personhood of the resident (Szczepura, et al. 2008). Quality is a term that can have many different meanings. In basic terms, quality can be used to define the material value of or superiority of a product. The term quality of life has become synonymous with satisfaction, feeling of personal and general well-being and social engagement (Anderson & Burckhardt 1999).

Residential care settings are struggling with how to provide quality care that is cost effective, meets statutory regulations and encompasses individualised care (Wagner et al 2001). The quality of care provided is often measured against process outcomes and how these outcomes impact on the quality and effectiveness of care, resident satisfaction and the impact on residents' quality of life (Donabedian 2002). These measurements, however, often fail to take account of the psychosocial

aspects of care. Moreover, the psychosocial aspects of care are often the most important in maintaining personhood.

Person-centred nursing has been described by McCormack (2004) as being associated with dimensions of "being": in a social world, in relation, in place and with self. Being in a social world, for example, refers to the context of care and the value of the biographical history in planning and in developing care. Being in a social world specifies maintenance of the connections and valuing residents' wishes for how they want to live their life. Both this maintaining and valuing enable a person's social world to remain part of their continuing care experience. Nolan et al (2004) and McCormack (2003) have described the importance of relationships as a central component of nurse/resident interactions. The place or culture where care takes place can either impact positively or negatively the care experienced by the older person. For example, a restrictive culture, one where innovation and change is not welcomed, results in a lack of opportunities for shared decisions and choices for older people in care. Knowing the self and being clear about what one values in life enables residential care staff to identify what is important to the older person and also assists with identifying ways to make meaning out of situations that arise in care (McCormack 2004).

Cohen-Mansfield and Parpura-Gill (2008) proposed that professional development of staff leads to staff empowerment and to the provision of care that enables residents to be autonomous. That is, professional development impacts on quality of care. It is well documented in the care environment that quality is a prevailing concern. Internationally, countries have developed methods and systems to address this. For example, governments in the USA, Australia, Ireland and the UK prescribe regulations to which care and nursing homes must adhere (Bartlett & Boldy 2001, Berlowitz et. Al. 2003, HIQA 2007). In other countries, Germany, Spain, Norway and New Zealand there is no requirement to adhere to regulations and nursing homes themselves adopt independent quality standards to improve leadership, quality of care or improve efficiency (Heras et al. 2008). In a review of the international literature on nursing sensitive quality indicators for nursing homes Nakrem, Guttormsen Vinsnes, Harkless, Paulsen & Seim (2008) found that of the seven countries examined, U.S.A, Australia, Norway, New Zealand, UK, Sweden and Denmark, all except Sweden had documented quality indicators for monitoring

nursing home care. There was however, little uniformity between them and the purpose of their use varied between countries. Quality indicators, in these countries, were used in the following manners: (a) to determine whether a person was eligible for high or low level care placement (Australia), (b) to assess if there was a need for care (Norway), (c) to generate data for care plans (New Zealand, UK, USA), (d) to determine health and social services resources (Sweedeen, Denmark, Norway) or (e) to determine payment (Australia, New Zealand, USA, UK) (Zimmerman 2003). This review demonstrated that quality indicators can be used to monitor and to improve care in nursing homes. To date however, the validity and reliability of quality indicators has not been extensively tested (Narkrem et al. 2008).

From Bio-medical to Person-centred Care

Internationally, there has been a move to shift the focus of residential care away from bio-medical models to those where the resident is at the centre of care and where the values and beliefs of both residents and staff are acknowledged and valued (Tullett & Neno 2008, McCormack et al 2010). Since the early 1990s there has been a lot of work developing practice that in some way takes account of the needs of older adults; thereby improving the quality of care and promoting the well-being for the resident (Reed 2008). In an effort to distance itself from the bio-medical model, nursing looked to nursing theorists for approaches to care that were theory generated. Nursing expected to uncover an all encompassing, one size fits all, model of nursing (Reed & Robbins 1991). This model of nursing was not discovered. Instead, several different competing models of care evolved, Orem's self care theory (1985) and Watson's theory of human caring (1988). These models were most often used as philosophical underpinnings of care (Norburn, Bernard, Konrad, Woomert, DeFriese, Kalsbeek, Koch, & Ory, 1995). The model most used to plan, evaluate and describe care in residential settings for older adults was the Roper, Logan and Tierney (Roper, Logan & Tierney 1996) Activities of Daily living model of care. Based upon the findings from the literature, it has been difficult to conceptualise within a specific nursing theory framework the impact and structure of nursing practice on care of the older adult (Nolan et al 2004). Often theories did not take into account the perceptions of the older adult regarding their expectations of care. Older adults in residential care may not be acutely ill but may need to be supported in the ageing process (Kelly, Tolson, Schofield & Booth 2005) and their values and beliefs need to be recognised when planning care.

In 1997, Reed and Peyton conducted a study to examine how older adults adapt when they move into care homes. Using a convenience sample of 41 prospective residents and 10 focus groups with 3-6 care staff of six high quality care homes, the residents reported relationships and interaction with other residents as being important. The researchers noted that care staff either did not recognise or had limited awareness of the importance of these relationships. In a qualitative phenomenological study using semi-structured interviews with 10 older adults, Buckley and McCarthy (2009) reported similar findings. The six themes identified were, superficial relationships, social isolation, outside world connection, mental ability, attitudes/actions of carers and substitution. These themes supported the understanding that the more social ties a person has the more socially connected they feel. These authors also recommended that services for older people should be shaped around maintaining connectedness and promoting integration of residents in long term care (Buckley & McCarthy 2009).

Reed and Peyton (1997) also stated that staff/resident interactions may impact negatively on other relationships in the community of care. They suggested that staff should try to facilitate the development of these relationships and attempts should be made to assess the social network of the care facility. Collectively, these two studies lack an approach of how to develop care where relationships are promoted and developed. In contrast, Cook (2006) conducted a hermeneutic inquiry to elicit the meanings that 8 older people ascribed to their life in the care home. Cook (2006) found that residents who moved to a care home valued relationships that were meaningful. The author also highlighted that residents employed strategies to maintain the relationships they had with friends prior to their move. The researcher was able to elicit this information by listening to the stories the older adults told. This approach to data collection has significance for the way information regarding the resident's life prior to admission is gathered and also for the way nursing supports residents in the maintenance of existing relationships and in the development of new ones. A framework that is based on knowing the person and taking notice of their values and beliefs would support the establishment and maintenance of social networks in care homes.

Despite nursing theory having been the buzzword of the 80s and 90s and influencing nursing for more than 50 years, Biley and Biley (2001) proposed that nursing theory's impact on nursing has been negligible and sometime troublesome. Dewing (2004) suggested that person-centred conceptual frameworks, while not models per se, are more acceptable to nurses than the older nursing theories and models because nurses can visualise their utility in practice. Person-centred and relationship-centred care has gained ascendance in recent years in the care of older people.

The Burford Nursing Development Unit Model (Johns 1994) described person-centred caring as the relationship that develops between the patient and the nurse, taking into account the individuality of the patient and the surroundings in which they are being cared. In Burford, the staff developed this understanding into a 'framework for nursing action', which enabled them to deliver care that was both effective and holistic. For example, by developing cue questions to ascertain valuable and relevant information, the Burford team were able to perform an assessment that was not intrusive but rather gathered relevant information in a non-prescriptive manner. Obtaining information in a structured admission assessment is sometimes seen as a task by staff and often carried out in a hurried manner, with a view to filling in the boxes and little thought given to the significance of the information obtained. The admission process however, is a time when valuable information can be obtained and therefore attention needs to be paid to the collection of relevant biographical information. The utilisation of a narrative framework during the admission process can ensure that relevant biographical information will not be lost and will be available to the nurse for the assessment, planning and implementation of care.

Kitwood, in the early 1990s, while working with older people with dementia, described personhood as the import a person or persons confers on another within the framework of a relationship. Kitwood's model of person-centredness "the enriched model of dementia" is based on intimately knowing the patient and caring for them in an empathetic way. In this model, Kitwood proposed that the "biological, psychological and sociological" aspects of dementia needed to be considered in order to truly understand how the person with dementia was feeling. Kitwood believed dementia care that focused on the disease and not on the person would not provide therapeutic care for that person. In his earlier work, Kitwood focused on

self-hood and stated that it applied to everyone (Kitwood 1990). He argued that everyone was capable of social being and of developing relationships. In his later work he changed from selfhood to personhood; his definition included 'bestowing' a 'standing or status' on the person with dementia implied that this standing or status could also be revoked (Kitwood 1997). It further placed the power in relationships with people with dementia outside the person and possibly with the caregivers. It was the caregivers who decided whether to 'bestow' personhood on the person with dementia. Dewing (2008 p11) argued that this bestowing was not the intent of Kitwood and despite limitations to his work, Kitwood is often unfairly critiqued for giving priority to 'individuality over concern for others'. She believed Kitwood's work to be based on a 'moral concern for others'.

Similar to Kitwood's work, Cook and Brown-Wilson (2010) in a cross study analysis of data collected from two previous studies, reported that functional social exchange outweighed relational social exchange. Functional social exchange focused on tasks, routines and expectations, while relational social exchange focused on sharing personal insights, experiences and mutual reciprocal dialogue. Moreover, relational social exchange minimised residents' opportunities for social exchange with staff and affected relationships between staff and residents. As previously reported, Reed and Peyton (1997) found resident to resident interaction to be the most important factor for residents. Similarly, Cook and Brown-Wilson (2010) found that staff and culture influenced the way residents experienced relationships in the nursing home. These researchers also reported that staff who focused on the functional aspects of care prevented a meaningful social interaction with residents. These findings suggest that staff need help in developing relationships with older people that promote social engagement and ultimately lead to the development of meaningful relationships. These findings resonate with Kitwood's (1997) conceptualisation of person-centredness. Biographical information could assist staff with this endeavour. Likewise ensuring that all care is based on a framework that supports narrative interaction would enable and support the development of these practices. Cook-Brown and Wilson (2010) reported that when a sharing of information occurred, residents and staff experienced a mutual understanding of each other's lives. They also identified that residents work to develop reciprocal relationships and recommended that strategies need to be developed to assist staff

with developing these relationships. The findings of this study further support the need for a narrative based framework in residential care facilities.

According to McCormack (2004) persons exist as individuals with a right to respect and to dignity. It is important that the care given to the person is holistic and is delivered through a shared understanding of the person. The care must meet the needs of the person and not the service, and in order for the person to maintain their personhood they must be allowed to make decisions about their care. Similarly, Kitwood (1997), in developing his model of person-centred practice, believed that the voice of the person with dementia should be heard alongside that of the carer and should have equal status. This approach can be achieved by a nurse who is competent and has developed interpersonal skills. This nurse has the ability to be responsive to patients and to learn from practice (Garbett & McCormack 2002). McCormack (2003) believed that nurses need to affirm the person that the patient is and that this can only be achieved by understanding the person's life as a whole.

Using Van Manen's phenomenological approach to determine the understanding of older person's experiences of receiving care and help in nursing homes, Anderberg and Berglund (2010) interviewed 15 older people aged 70 years and over, in 4 nursing homes in South East Sweden. They found that older people tried to adapt to the patterns of the nursing home rather than the nursing home recognising and maintaining their existing patterns. They also found that residents were interested in ensuring they understood the staff's interests as this gave them a starting point to initiate interactions. The researchers however, did not say if staff reported being interested in the older adults experiences; this limits the value of the study findings. This study highlights the importance of meaningful interactions as a way of giving sense to life and maintaining self for nursing home residents. This approach however, is limited by what people's perceptions of needing care are. Given that these older people experiences may not be the same as others in different locations, it could also be said that what these residents perceive as needing could be different for another cohort of nursing home residents. Regardless of limitation, these findings pose an interesting question around interaction and the added value of interactions towards feelings of well-being and/or perceptions of care for older people. Perhaps a caring interaction that is based on a narrative approach and takes into account the life experiences of the older adult, would be beneficial both in

terms of recognising the selfhood of the individual and in promoting engagement and interaction to the mutual benefit of both residents and carers.

Common among researchers who study person-centredness and person-centred practice is the maintenance of relationships that are based on a mutual understanding of what is important to the individual, as well as, utilising that information to promote well-being (McCormack 2004). Despite the explosion of literature in relation to person-centred care in recent years, a fragmented view of person-centredness exists, among studies where researchers report the person-centredness of the dining experience, emergency room admissions, communication, rehabilitation, symptom and disease management, medication rounds and workplaces (Cott 2008, Edvardsson, Winblad & Sandman 2008, Lee 2008, Bolster & Manias 2010, Hung & Chaudhury 2011).

A key element in identifying person-centredness is the recognition of the 'embodied self' (Dewing 2008). It is this recognition of the 'embodied self' through respect for the person's complete biography that, according to McCormack and McCance (2010) allows others to know 'who I am'. Therefore, while it is good to explore person-centredness in relation to specific patient experiences, this type of investigation may not in fact acknowledge the all encompassing picture of personhood. If the 'embodied self' is the way we inhabit our world or how our bodies experience the culture where we live, then in order to truly explore person-centredness we must take these aspects into account (Dewing 2008).

Building on Kitwood's (1997) focus on personhood, the significance afforded by one person to another within a relationship, McCormack (2003) analysed the conversations and interactions nurses had with themselves, patients and other members of the team. From this hermeneutic study, comprised of a convenience sample of four hospital nurses, McCormack developed a conceptual framework for person centred practice with older people. McCormack (2003) described person-centredness as authentic consciousness. He proposed that nurses can only really practise person-centred care when they are fully aware of the whole life biography of the patient taking account of the context where care is occurring. McCormack (2003) outlined five "imperfect duties" that promoted autonomy and ensured that the personhood of the patient was respected in a genuine way. These "imperfect

duties” are informed flexibility, mutuality, transparency, negotiation and sympathetic presence. The imperfect duties encouraged a more open discourse between the nurse and the patient, and promoted negotiated care. This care recognised and respected the values of the patient and enabled the nurse to act as a 'facilitator of authentic consciousness'. It is through this discourse that nurses learn about the physical, social, psychological and psychosocial aspects of the patient's life and through this knowledge and awareness gain a deeper understanding of the true self that is the patient. True self is based meaningful engagements and interactions that narrators have with others over a period of time (Smith & Sparkes 2008). While the values espoused by this framework are aspirational, it may be difficult for nurses, particularly inexperienced ones, to attain a level of interaction with patients where they are truly facilitators of authentic consciousness. Similarly, it may also be difficult for nurses working in areas of high turnover and high acuity such as emergency departments to also attain this level of understanding.

Nolan et al. (2004) discussed person-centredness and argued that individualised care did not fully address the interconnected relational aspect of that care. Nolan et al. (2004) proposed that adherence to the six elements of their framework, as outlined below, promoted a caring environment that was inclusive of all who care for the patient, as well as promoted interconnected relationships.

The Six senses framework.

A sense of security – to feel safe within relationships.

A sense of belonging – to feel “part” of things

A sense of continuity – to experience links and consistency

A sense of purpose - to have a personally valuable goal or goals

A sense of achievement – to make progress towards a desired goal or goals

A sense of significance – to feel that “you” matter.

Nolan et al. (2004)

Ryan et al (2008) believed that when these six elements were used with a person with dementia it would enable positive relationships to occur between the person, their families and the care staff. Nolan et al. (2004) believed that the Senses Framework provided a framework that took into account the importance of relationships and the personhood of both those receiving and giving care. Brown

Wilson et al. (2013) reported that using the framework to implement a biographical approach to care planning enabled staff to gain a deeper understanding of the person with dementia. While the aspirations of this framework are admirable, according to Dewing (2004) it does not provide any concrete guidance to nurses on how to operationalise the framework but rather is a set of principles that could best be used to underpin the implementation of a practice development project. The framework as outlined may also have little or no relevance for some older adults. The sense of achievement and purpose particularly may not hold meaning for well older adults with dementia including those who have no desire to have goals or those who have the inability to express their desire regarding goals. Another limitation of the framework is the sole focus on relationships; other influences such as context or culture may also hold value.

Recognising that nursing attributes, environmental/organisational factors, and patient traits also influence person-centredness, McCormack further developed his authentic consciousness framework. and in conjunction with McCance (2003) developed the Person-Centred Nursing Framework (McCormack & McCance 2006, 2010). This framework is a combination of two existing frameworks (McCance 2003, McCormack 2003) and has concepts that are central to both. While McCormack's framework is based on autonomy and a mutually beneficial relationship between patients and nurses, McCance's framework portrays the process of caring from the perspective of the nurse and the patient. The Person-Centred Nursing Framework provides a platform on which practice with older people can be built (McCormack & McCance 2006). In contrast to Nolan et al's (2004) Senses Framework, the Person-Centred Nursing Framework takes cognisance of the professional abilities of the nurse, the environment where the care is taking place and the processes used to carry out that care. While the authors of the framework recognises the value of biography in the development of person-centred relationships, what is common to this and the other frameworks outlined here is that the process of recognising or incorporating that biography into the caring moment has been lacking. However, this framework will be used to underpin the present study and will be explicated further in the philosophical perspectives chapter (Chapter 4).

Culture Change Movement

In the USA, the lack of focus on evaluation of care has led many nursing homes to look at model clinical practice systems. These systems are used in an effort to change the prevailing culture and improve the quality of life for residents (Reinhard & Stone 2001, Fagen, 2003, Thomas 2003, Wiener 2003). Models of care such as the Pioneer Network (Fagen 2003), the Eden Alternative (Thomas 2003) and the Wellspring model (Reinhard & Stone 2001), offer frameworks for nursing homes to improve the quality of life of residents. They propose that quality is improved by adopting the values of knowing the person, putting the resident before the task and utilising reflective practice.

The Pioneer Network or the culture change movement was founded in 1975 to promote a change from institutional driven models of long-term care to a more consumer driven model. The Pioneer Network is a collection of organisations, such as The Eden Alternative, the Wellspring Model and the Live Oak Regenerative Community. The network advocates resident-centred and individualised care. The Pioneer Network has taken the lead nationally in the USA in creating, coordinating and sharing information and templates. The network also act as a resource for organizations and individuals who are interested in promoting a new culture of ageing and elder care (Fagen 2003).

In 1991 Dr. William Thomas, a Geriatrician founded the Eden Alternative in the USA (Thomas 2003). This model of care is based on eliminating loneliness for older adults through providing an environment where life revolves around contact with plants and other living things, and where the autonomy of the resident is valued (Thomas 2003). To date there are 300 registered nursing homes in the US, Canada, Australia and Europe using Eden principles of ageing as a stage of continued development. These facilities strive to implement culture change through recognition that loneliness, boredom and helplessness make life unbearable. They believe that the opportunity to give care to other living things enhances the quality of life of residents (Thomas 2003). Facilities that have adopted an Eden philosophy have shown increased quality of care and involvement in decision making for residents, increased staff retention and recruitment and a decrease in polypharmacy and restraint use (Bergman-Evans 2004). In 2004, Bergman-Evans conducted a quasi-experimental study, comparing an Eden Alternative group of residents (n=21)

with a comparison group ($n = 13$), to determine the impact of the implementation of the Eden Alternative. Data analysis from the post-implementation phase revealed significant differences between the groups on levels of boredom ($p = .01$) and helplessness ($p = .03$). The researcher found, post implementation of the model, that levels of boredom and feelings of helplessness were decreased in residents while levels of loneliness were unaffected. However, the small sample size and large attrition rate limits generalisability of this study.

There has also been some evidence that residents in Eden homes received higher amounts of psychotropic medications than those in traditional homes (Andersen et al 2014). This has been linked to the model's focus on consistently assigned staff. While earlier research (Bergman-Evans 2004) reported that adoption of the Eden philosophy led to lower levels of restraint use and decrease in loneliness, more recent researchers (Andersen et al 2014), conducting a scoping review, found the practice of consistently assigning staff led to lower tolerance levels amongst staff to responsive behaviours and an increase in requests for psychotropic medication for residents. It is also probable that while some residents and care assistants will have mutually pleasant relationships others will not and the resulting quality of relationship could be detrimental for both the resident and the staff.

While the Eden model focuses on a philosophy, the Wellspring model while also having a particular philosophy of care, also focuses on sharing services and resources between several organisations. Developed in 1994 for an alliance of 11 nursing homes in Wisconsin USA, the Wellspring Model of care is reported to improve the quality of life for residents, by improving the working conditions for staff and providing a structure and set of processes to improve quality (Reinhard & Stone 2001). Wellspring focuses on both clinical practices and culture change, which distinguishes it from other programmes (Stone & Reinhard 2001). The model is based on leadership, identifying and sharing best practices, translating best practice into action and accountability (Kehoe & Van Heesch 2003). Wellspring is a complex model for nursing home reform and values not only residents but also all employees. Wellspring homes have formed a quality enhancement alliance to identify sharing information and best practices and minimise competitive behaviour. Wellspring has adapted the National Minimum Data Set (MDS), to capture information they believe is more relevant to their organisation. Staff are involved in all decisions about the

care environment and there is a 'no blame' culture (Stone et al. 2002, Kehoe & Van Heesch 2003,). The goal of the Wellspring Model is staff empowerment. An alliance of 3-12 nursing homes is critical for successful implementation of the Wellspring Model of Care (Kehoe & Van Heesch 2003). A geriatric nurse practitioner is shared between these sites to facilitate training and assist with the implementation of guidelines in physical assessment, continence management, skin care, accident prevention, restorative care and nutrition. All employees participate in decision-making regarding care of the residents they serve and all staff have permanent work assignments (Reinhard & Stone 2001). However, nurses were often confused over their role and had difficulty integrating individual resident care with good quality nursing care, this often led to conflict within the team over the implementation of the culture change (Mueller 2008). The Wellspring model was taken over by the Eden Alternative in 2012 and it is possible that integrating the philosophy of both models will strengthen the person-centred focus of these models. To date however, research has not been conducted on the effectiveness of the new integrated models of care.

In the US, the organisations involved in the implementation of these models have also developed collaborative learning networks whereby they share learning and educational resources. American nursing homes that have adopted these models of care have shown high compliance with the regulatory MDS quality indicators (Wiener 2003). Andersen et al. (2014), in a scoping review on the effectiveness of these models of care, found that 53% of culture change adopters enable residents to choose their own schedule compared to 22% of traditional nursing homes. What is significant about these figures is that 47% of those nursing homes that are culture change adopters do not allow residents to determine their own schedules.

Lee, Yu and Kwong (2009) conducted a literature review on quality of life issues among older people in residential care. The researchers reviewed 18 papers and identified several different interventions as important for the maintenance of quality of life. Key interventions identified were environmental improvements and programmes that focused on making the care more person-centred. Similarly Gage, Knibb, Evans, Williams Rickman and Bryan (2009) conducting an empirical study in all 258 nursing homes in one county in England, on why some care homes are better than others, found that quality of care was statistically associated with the

features of the nursing home and the characteristics of the residents. Interestingly, Gage et al. (2009) found that for-profit facilities provided better quality and superior care than not-for-profit providers. This difference in quality was mainly due to value for money expectations of residents and families, and contrasted with American studies (Hillmar et al. 2005, Grabowski & Stevenson 2008) where for-profit providers were found to have a lower quality of care often associated with cost cutting measures. Gage et al. (2009) also found that the implementation of national minimum standards in 2000 in England led to higher quality of care. Care homes registered prior to 2000 did not have a requirement to adhere to these standards. The authors reported that standards and regulatory inspections can improve quality, that the facility's cultural organisation needs to be taken into consideration, and that focusing on what matters to the residents is important.

Venturato, Kellet and Windsor (2006) found that nurses reported a tension between feeling valued for their work and working in an environment where the care provided was regulated and policy driven. Exploring the influence of policy reform on the experiences of RNs working in long term care, the researchers found that failure to regulate staffing levels and poor remuneration for staff led to this tension. This work tension has led to difficulties with staff retention and recruitment, and the provision of quality care for older people (Nay & Closs 1999). In the past, residential care in the USA has been a 'patchwork' of differing methods and providers of care (Lehning & Austin 2010). Residential care has not had much of a political voice and this has led to poor, inadequate and sometimes abusive care (Lehning & Austin 2010).

The Culture Change movement has attempted to change and reshape the way residential care is delivered. Despite this movement being embraced in State quality improvement guidelines, there is a dearth of research to support claims that culture change improves outcomes for older adults (Hill et al, 2011, Andersen et al. 2014). Research has shown an increase in culture change practices leading to a decrease in nursing home deficiencies (Castellanos-Cruz 2008). These findings for restraint use and pressures sores may have resulted because of national targets being set as opposed to the implementation of culture change practices. Coleman, Looney, O'Brien, Siegler, Pastorino, and Turner (2002) however, in a study to determine effectiveness one year post implementation of the Eden Alternative, were unable to show any significant improvements in mortality or functional status of

residents. The study was conducted using an experimental (N=95) and a comparison group (N=79). The MDS was used as the data collection instrument. Perhaps the lack of significant findings can be accounted for by both choice of measurement tool and the short time between implementation and testing. . It is also possible that morality and functional status were not appropriate measures of quality of care and thus may have impacted on the failure to identify any significant improvements

In a recent review of the literature on culture change implementation effectiveness, Hill et al. (2011) reported inconsistent health benefits to residents, however psychosocial health was maintained within the models used in the literature reviewed. The review noted the dearth of research focusing on the outcomes of culture change movements with only 11 studies included in the review. The authors also identified that research currently available is of a low grade with most studies reviewed assigned a D grade. This grading was based on the guidelines for grading evidence developed by the Scottish Intercollegiate Guidelines Network (SIGN). In these guidelines, research was assigned grades from A to D; A being the highest level and D the lowest. (Harbour & Miller 2001). In Hill et al's (2011) review, four culture change models, the Eden Alternative, Green House Project, Wellspring Innovative Solutions and Resident Centred Care initiative were tested. Low grades were assigned to the studies due to their small sample size, lack of comparison groups, failure to control for extraneous variables, using the MDS as a data collection tool and the inability of the study design to measure quality of life of residents. Hill et al. (2011) called for the implementation of a professional nursing practice model alongside the culture change model to both drive and embed the change. While all literature reviewed purported to value the personhood of the resident and promote dignity and autonomy, none specifically took account of the prior life experience of the resident and how this may impact on their current care needs. Hill et al. (2011) did not note this limitation.

Conclusion

Professional development of staff impacts on the quality of care provided to residents in long term care. Internationally, there has been a move away from biomedical models of care to ones that are person-centred and holistic. Interaction

and value of life experience has been shown in the literature to have a positive effect on feelings of well-being. However, the existing evidence remains fragmented about what is person-centredness in residential care settings. There are several models of care based on person and personhood but, according to Dewing (2008), none of them provide guidance for nurses on how to operationalise person-centred care. Since 1975, the culture change movement has been providing frameworks for nursing homes to improve the quality of life for residents. While reviews of these implemented models have shown a decrease in nursing home deficiencies, to date there is limited evidence showing improvement in quality of life for older adults living in these settings. Furthermore, the gathering and utilisation of biographical information both within the person-centred models and frameworks, and the culture change movement has been a haphazard exercise. That is, model developers acknowledged that the gathering of biographical information was useful, but paid lip service as to how that information should be utilised in practice. The next chapter will present a literature review of Narrative and its use in healthcare settings.

Chapter 3: Narrative Approaches and Use in Healthcare Settings.

Introduction

This chapter will discuss what narrative is, its use in healthcare, and its relationship to person-centred care. This discussion will follow with an exploration of the use of narrative to inform intervention or change.

In developing this review, I searched the databases CINAHL, PUBMED, AND PSYCH INFO using the keywords autobiography, biography, life story, life history, narrative, narratology, and narrative inquiry. I also searched Google Scholar and conducted manual searches of books and journal citation lists. The search terms and limits used in this comprehensive search and search results are outlined in Appendix 1.

Narrative research has been described as the study of life events, stories, or accounts of actions (Clandinin 2007). Narrative inquiry encompasses both the experience under investigation and the methodology used, and is underpinned by theoretical literature (Clandinin & Connelly 2000). Since the 1980's, researchers have been struggling with the way they interpret research data that is both true to the subjects under investigation and reverberates with the data. Some researchers hold the view that the researcher and the researched exist in a 'unique' and separate context. The way interpretation occurs between the two can shape and change the way the research is conducted and interpreted. In order for a complete understanding of narrative inquiry to emerge, researchers must let go of their objectivity and embrace the concept of researcher/researched relationships and how these impact on the research (Clandinin & Rosiek 2007). The popularity of narrative as a method of social research can perhaps be explained by its cross-disciplinary and interdisciplinary applicability, and because of its ability to bridge the theory practice gap and facilitate the translation of research into practice. Narrative has a long tradition within psychology, anthropology, and sociology, as well as, in literature and in the arts (Squire 2008). Most recently, narrative has found favour in healthcare; its utility in interpreting and in improving the human experience has proved valuable in this field of research. In the care of the older adult settings, narrative research has been used in a variety of ways including exploring older

adult/nurse relationships, understanding dementia and reminiscence therapy, and to help healthcare professionals understand the experiences of those living with chronic conditions and those in residential care settings (Ironsides et al. 2003, Surr 2006, Heilker 2007).

A person's life story does not contain all the memories of their past; that is, these may not be relevant to describe the story of their life (Bluck & Habermas 2000). Memories that have personal meaning or are very significant, are usually those that are included in the narrative. A person's life story is made up of both remembered events and experienced events (Clarke & Warren 2007). These memories are both emotive and rational, and have the potential to be motivational. The life story can also be affected by the existing context of the person and/or their previous experiences (Leight 2002). Often stories have a theme that runs through the story or sometimes will only emerge when the story is told. This theme assists the teller to organise the story in a step by step process (Kelly & Howie 2007). The told story however may not be a representation of the remembered story. The story is often adjusted to suit the particular situational context the narrator finds himself or herself in, or may be adjusted to suit the perceived motivational demands of pleasing the interviewer (Gubrium 2001). Repetitive telling of the narrative embeds it in the narrators psyche, facilitates the development of a 'good story', and confirms the identity of the teller (Hyden & Orulv 2008). Stories are more beneficial when drawing abstract principles of life experience through closed interview as they are often closer to the lived experience and require less effort to impart (Sandelowski 1991).

Narrative combines both facts and significant events (Kenyon & Randall 2001). "Narratives help guide action and are a psycho-socio-cultural shared resource that give substance and texture to people's lives" (Phoenix, Smith & Sparkes 2010 p.2). Narratives give us insight into the ageing process and how it affects our lives. That is, narratives can teach us about the difficulties of growing older and how we create different identities at different life stages. In times of change or emotional uncertainty, individuals often look back on past experiences in order to plan for the future. Narration allows the narrator to create his/her identity. Often the way the individual evaluates their life situation now is shaped by their experiences in the past and their expectations for the future (Paley & Eva 2005, Bluck & Habermas 2000).

Older adults in residential care settings want to make meaning of their life events and this desire is often motivated by a need to see a purpose to their life, or to be seen as important (Gaydos 2004). In their narratives they may explain their current situations as a natural progression of their life, in other words being in residential care was not their choice but the next step in their life.

Narratives in healthcare

The terms narrative, life story, and story have all been used in nursing research to explicate lives and to value human experience (Frid, Ohlen & Bergbom 2000). However, some researchers believe that these terms should not be used interchangeably (Fried et al. 2000, Paley & Eva 2005,) while others believe a person's life story is their narrative (Bluck & Habarmas 2000, Kelly & Howie 2007, Hyden & Orulv 2009). Narratives have generally given practitioners an insight into how patients cope with illness or how patients journey through the healthcare system. Narratives have usually been used to inform the development of interventions, to offer support and to assist people to deal with these situations (Hardy, Gregory, & Ramjett 2009).

Personal narratives have importance for aesthetic knowing and for use in qualitative research. Paley and Eva (2005 p.85) believed that “while all stories count as narratives not all narratives count as stories”. They described narratives as containing many steps that are interwoven and dependant on one another. The furthest step in this continuum is story, which is the total drawing together of all the steps to form a whole plot. Frid et al. (2000) agreed with this and further stated that narrative is the telling of one's own experience, whereas story can be told by others who have not actually experienced the event. Denzin (1989) as cited in McCance, McKenna and Boore (2001) disagreed and claimed that narrative and story are synonymous and along with other researchers (Bluck & Habermas 2000, Kelly & Howie 2007, Hyden & Orulv 2009, Phoenix, Smith & Sparkes 2010) believed that narratives must contain a beginning, middle and end, and be structured around a plot. Paley & Eva (2005) echoed this and further prescribed that the narrative must have unity and each part of the narrative must contribute in some way to the outcome.

Rimmon-Kenan (2006) stated the meaning of narrative and narratology can change according to its origin, i.e. in what genre it originates or the type of narrative

expressed. That is to say, narrative in the literary or cultural world can be verbal, written, or visual and this type of narrative represents an event rather than tells about the event. Narrative in the social sciences are verbal or written and according to Rimmon-Kenan (2006) are the telling of a series of events that may or may not be true. Paley & Eva (2005) further clarified that the narrator provides an emotionally invested account of an experience and therefore believes this is what happened. These authors also assert that narratives give us an insight into what is unique about a person. Narratives have been used to gain an understanding of patients' illnesses and to use that knowledge to plan and implement care (Fried et al. 2000). By understanding the narrative, nurses can help patients accept and understand their illness, and provide a forum where nurses and patients share in the decisions regarding treatment and care options.

Narrative creates a link between the person's past, present and future. Hyden and Orulv (2009), in a qualitative study focusing on the performative aspects of storytelling, utilised video data collected with eight residents who had a diagnosis of dementia. These researchers explored how people with Alzheimer disease (AD) used story as a resource to maintain their identity. They found the stories told were often shared to give the listener insight into who we are as people and our standing in society. The development of these stories shape our recognition of our sense of self. They hypothesised that stories connect our past with our present and tell us how events in the past have led to us being here in the present. This research supports the assumption that stories told in different situations to different people are a way of presenting the moral self of the teller. In other words, our story reflects our true identity. Our true self or true identity is conceptualised through the meaningful engagements and interactions we have with others. The authors believed their study offered an opportunity for engagement with people with AD, and that both verbal and non-verbal aspects of narrative should be considered when analysing or determining a person's narrative and also their identity. This study however, is limited in its generalisability as only one case was considered. In addition, the researchers did not consider the progression of the person's AD and whether this would affect the interaction and the ability to present a narrative that was meaningful to both the teller and the listener.

Narratives in healthcare are often co-created. That is, patient and nurse interactions can shape how the patient recounts their story. This process can be described as the art of nursing and can provide a therapeutic environment for patients where the person listening to the story is caring (Gaydos 2004). Narrative practice, or life story, is “also seen as part of the humanistic, person-centred approach” (Taylor 2002) that forms the basis of everyday nursing care. Life story is about recording elements of a person’s life and using that information to improve their life (McKeown, Clarke & Repper 2006). Life story work can benefit many aspects of health care. It can improve person-centred care and help staff see a vibrant person, not an older dependant one (Price 2006). Life story can assist staff when assessing and planning care, and help them understand certain behaviours that may challenge their ability to care for the patient. Life stories attempt to influence an area of practice for improvement (Kelly & Howie 2007). Life story work enables staff to see the patient as a person, to understand their family background and situation better, and to help staff form a common bond with the resident (McKeown et al. 2006).

Describing the use of story to inform the art of nursing, Leight (2002) stated there are two main sources of nursing knowledge, empirics and aesthetics. Empirics deals with scientific or theoretical knowledge, whereas aesthetics deals with creativity and intuition. Nurses need to be aware of both types of knowledge in order to plan and implement care. Knowing the person and exploring the contextual discourse shaping the reality of their situation enables a deeper understanding to occur between the nurse and the resident (Crowe 2000). By understanding these narratives, nurses can transform practice and develop plans of care that are based on a shared understanding. The practice of narrative can often lead to self-revelation. Self revelation occurs when the nurse and the resident have a trusting relationship (Gaydos 2004). Narrative also allows residents to organise important events and remember significant life memories (Hanesbo & Kihlgren 2000). By working with residents to get to the deeper meaning of their story, nurses can create openings for therapeutic discussion (Randall, Prior & Skarborn 2006). More specifically, narratives explain the resident's understanding of how their past was shaped. Using narrative in health care can enable residents to connect with others, express their own identity, and give meaning to their lives (Clarke & Warren 2007).

In a qualitative study, Carter (2010) interviewed 12 community nurses and found that nurses use narratives of their work experiences to gain an understanding of the motivation for their careers. The participants identified poor work practices as “crisis or atrocity” events and were quick to distance themselves from these poor practices. This distancing has implications for the way reflective or clinical supervision is carried out. That is, if nurses always believe that the institution is responsible for their poor practice then there is little or no learning to be gained by reflecting on an event. These stories offer a unique insight into what it means to be a nurse and shed light on experiences of either helplessness or emancipation. While the sample used in this study was small and specific to one particular area of nursing, the study was replicable and generalisable. Researching narrative practice and developing narrative frameworks, provides both nurses and patients with a communication tool that can impact on the quality of care provided. It also ensures the care is individualised and specific to the patient.

By hearing or by reading a story we see it through our own life interpretation. This interpretation, according to Polkinghorne (1988), causes the story to also become our experience. That is, the meaning of the story is created by both the resident and nurse. This created story leads to engagement, mutuality, reciprocity, and sympathetic presence (McCormack 2003). Resident narratives occurring within the cultural context of long-term care are shaped by the reality of where the resident is at that particular moment in time. Nurses must be able to take account of the context within which the story is being told (Holstein & Gubrium 2000). By listening to the recounted story, nurses can empower residents to own their story and shape their care (Leight 2002). Through this listening, nurses may be aware of the technical knowledge but not the personal knowledge that residents possess through their lived experience. Residents can be known and their lives can be informed by the narratives they tell (Randall et al. 2006). Narratives help nurses and residents have glimpses of their mutual experiences, which can offer opportunities to develop new ways of working as a result of this sharing (McCormack 2003). Stories explicate lives and value human experience. The use of narratives in research means that nursing practice has begun to value other concepts in delving into the lived experience of human lives (Sandelowski 1991). This is recognition that more than one paradigm is capable of providing knowledge and that narrative is

particularly capable of being used in the human sciences to both inform and develop care practices (Leight 2002).

Illness Narrative

Narrative analysis has helped nurses gain valuable insight into the patient experience and into the development of holistic care patterns for patients (Sakalys 2003). Illness narratives, are the stories patients tell to explain their whole experience and are not just based on the illness or the treatment received. Reflection on the illness narrative helps the patient come to terms with the illness and re-establish their sense of self identity (Sakalys 2003).

In an interpretative review to determine how narrative can help patients gain health through understanding their suffering, Fredriksson and Eriksson (2001) found that caring conversations helped patients find meaning in the way they experienced their illness. The literature review for this study concluded that bearable suffering, where the individuality of the person is recognised, is seen by patients as part of gaining health. The researchers also found that patients want their health to be maximised and their identity to be recognised while at the same time having their suffering relieved. This led the researchers to develop a model for 'narrative understanding in a caring conversation'. This model enables healthcare professionals to gain a deep understanding of the unique identity of the person for whom care is being provided. Through this model, the researchers believe that health care professionals can gain a deeper understanding of the patient's suffering and the co-creation of an illness narrative can lead to better patient care outcomes (Fredriksson & Eriksson 2001). Utilising a model that only focuses on the illness episode without taking cognisance of other aspects of the life experience of the person may pose a danger of distancing the person from their inner self. Placing focus on the biomedical episode rather than on the personhood of the patient increases our understanding of the suffering experienced by patients but does not increase our understanding of the person (Nochi 1998). Continuing work in this area, Dewar (2011) has developed a model of Compassionate Relationship Centred Care. In this model, Dewar focuses on caring conversations between staff, patients, and families as a way of getting to know the person, what matters to them, as well as an aid in development of relationship centred care. This model places more emphasis on obtaining knowledge of the person and using that knowledge to develop person centred care

rather than focusing on the person's illness. While Dewar and Nolan (2013) state this model needs further development it is none the less a step in the right direction and highlights the usefulness of models of care based on knowing the narrative of the person as a way of ensuring the care experience is based on that knowledge.

Pownall (2004) using a patient narrative to explain what the hospitalised experience was like post hip fracture, highlighted that lack of therapeutic relationships can lead to mis-management and poor patient outcomes. This is similar to Carter's (2010) study on nurses' experiences of critical events revealing how nurses' responses to these events can shape the way they practice. In interviews with 12 community nurses and health visitors, the researcher elicited reflective accounts of particular stressful events in the respondent's careers. Carter (2010) believed that the way nurses reacted to these events shaped the way they now practise and that the experience of nurses, good or bad, can influence the experience of patients. While this finding could be considered a fairly predictable conclusion, it nevertheless illustrates that personal narrative has a place to play in the therapeutic nurse/patient relationship. Sakalys (2003) agreed and further stated that where nurses and patients co-create the narrative experience they develop a foundation on which the nurse-patient relationship can be based. While co-creating a narrative experience may seem unrealistic in everyday practice due to time constraints and workload, evidence supports the fact that where therapeutic relationships occur patients have better care outcomes (Heliker 2007).

In a research study, using Heideggerian hermeneutical phenomenology to determine what it is like to live with chronic illness, Ironside, et al. (2003) found that focusing on narratives can help nurses make meaning of patients experiences. The researchers used open-ended semi-structured interviews with a sample of two researchers, five nursing students, and three citizen participants. Three common themes emerged which enabled the researchers and co-participants to reflect on their understanding of chronic illness in a different way (Ironside et al. 2003 p.175) as explicated by these themes. The themes were:

- focusing on functional status does not adequately account for the experience of chronic illness.
- Decentering the focus on the treatment of symptoms makes way for equally important discussions of meaning making in the context of chronic illness.

- The objectified language of healthcare covers over how chronic illness is experienced.

By involving the citizen participants in the analysis, the researchers were able to maintain rigour and develop new understandings of the data that may not have been possible if these co-participants were excluded. Their unique insight into living with a chronic illness enabled them to confirm or challenge the interpretative analysis. The researchers, by employing this approach valued the input of the citizen participants and acknowledged that they were best placed to provide an explanation of lived chronic illness.

Patients, their families, and healthcare staff can better comprehend the illness experience by creating their own personal narrative about the episode (Baider 2008). Being able to identify and describe the experience promotes communication between the patient, family and healthcare professional. Baider (2008) suggest that being mindful of the patients narrative of their illness can enable nurses to have meaningful engagement and interactions with the person and their family. However, they failed to make any recommendations as to how this may be achieved except to say that clinicians should document client's experiences of living with chronic illness. This may be a limitation of the study. Promoting a focus on the loss of functional ability, building the narrative experience around this and not on the loss in the context of their wider narrative may lead to interactions that are prejudiced by the illness. These types of interactions do not take account of the personhood of the patient (Weingarten 2001). Simpson (2004) used a narrative picturing method in a study with people who self-harmed (cutting). Her aim was to help the participants identify reasons for and experiences of self-cutting. The researcher found that narrative picturing can promote collaboration between patients and staff. However, the method often inhibited the participants who emphatically stated they did not have visual memories and that they were unable to create pictures of their memories. This suggests that while the method can help willing participants unlock their stored memories, it may however be necessary to employ several different methods in order to gain more insight into the illness experience of these patients (Simpson & Barker 2007).

Brown and Addington-Hall (2008) in a longitudinal study, using narrative interviews with 13 adults who over an 18 month period were coping with motor neurone disease (MND), identified 4 types of storyline - sustaining, enduring, preserving and fracturing narrative storylines. These storylines can help others understand where those who suffer with MND are with respect to their illness and offer nurses opportunities to understand how the distress caused by MND is felt. While the study only identified 4 storylines specific to a particular chronic illness, perhaps because of its small sample size, it does offer nurses the opportunity to understand the experiences of people living with all chronic illnesses (Brown et al. 2008). Using the storylines identified by Brown et al. (2008) can help nurses identify where patients feel they are in their illness trajectory. It also offers the patient the opportunity to see their lives and their illness in a new light.

Some healthcare workers discourage patients from telling their stories in order to maintain a professional distance from the patient. Both listening to the story and encouraging the person to relate it are important events in maintaining patient autonomy and participation in the health care journey (Langer & Ribarich 2009). Hardy, Titchen, Manley, and McCormack (2006) investigated nursing practice expertise and concluded that healthcare professionals often need training to enable them develop the skills required for shared decision making. Traditionally, nurses may have been educated in a system where patients/residents were informed of the care that was going to happen to them and not offered choice (Hardy et al 2006). Narration provides a vast repository of knowledge that can help us inform care and enhance nursing practice (Kenyon et al 2001). Co-constructed narratives lead to a shift in the power balance from one where nurses are the dictators of care to one where nurses and patients are on an even footing (Hardy et al 2006). Clandinnin and Connelly (2000) believed that all narrative and narrative interactions are co-constructed. How a person shapes and explicates their narrative is done with a perceived audience in mind. The perceived audience influences what the narrator says and does not say, whether they are listening to the narrative or not. Therefore, meaning in clinical practice is co-constructed between the patient and the healthcare worker.

Early work on narrative discourse analysis, such as that undertaken by Labov and Waletzky (1967), claimed that narratives were told by narrators and accepted by

listeners as the full meaning of the narration. More recently researchers have questioned this and stated that narrative is an “interactive process” between the story teller and the listener (Nye 1998). Narration can encompass both heuristic and negotiative processes. In a narrative that involves heuristic processes, the teller tells the story but is not sure of the meaning and invites the listener to help construct the meaning. In a negotiative narrative, the teller tells a story they are happy with but the listener questions the story in an attempt to arrive at a better understanding of it. This questioning may be resisted by the teller and can lead to the story being reformulated. This sharing of power implies that the narrator is willing to be vulnerable and the listener is willing to give time to the co-construction. Nye (1998), using vignettes from sessions with one client over a 2 year period, described how social workers and clients can develop co-constructed meaningful narratives. She cautioned that co-constructed narratives often bring up issues of tension and power. In everyday narratives these processes are often shared between the narrator and the listener. However, in a therapeutic relationship these may be exacerbated. It is the practitioner’s responsibility to recognise this and ensure that both the narrator and listener are responsible for their own “power of construction”. Nye (1998) described this as collaborating sympathetically with the narrator so they can identify the meaning of the narrative in an environment that promotes trust and safety. Similarly, Hardy et al. (2006) believed that research should include the voice of all stakeholders, i.e. patients, families, nurses and carers as they are able to formulate future care by taking part in the research that shapes it. However, Nye’s (1998) research study illustrates that using narrative based approaches can be difficult and complex for both practitioners and patients where issues of power and vulnerability exist and that these approaches need to be adopted sensitively and carefully.

Narrative and Reminiscence

Reminiscence as defined by the Webster Dictionary is “a recall to mind of a long forgotten experience or the thinking about or retelling of past experiences”. A synonym for reminiscence is memory (Webster 2004). In order to provide person-centred care for people with dementia it is essential that we understand their life history (Brooker 2004) and in so doing have access to their memories.

Narrative can provide a link between the past, present and future (Holloway & Freshwater 2007). However, circumstances or events can have an effect on the

way the narrative is remembered (Roberts 2002). Circumstances occurring after the event can cause it to be remembered differently from the way in which it occurred (Holloway & Freshwater 2007). Memory is selective and we all remember in ways that place ourselves in a good light and minimises trauma (Greenhalgh 1998). According to Hansebo and Kihlgren (2000) “memories make up the framework of a person’s life story”. This is echoed by Surr (2006) who believed that narratives us an idea of who we are and that our memories are reconstructed accounts of our experiences based on how we see, assimilate and interpret events. She further purports that storytelling is an important function of self-identity.

Reminiscence is central to all narrative action (Hodges and Schmidt 2009) and there has been considerable debate in the literature regarding the benefits of reminiscence. For example, several researchers believe that reminiscence can help older adults to cope with stress or adjust to social isolation and loneliness (Wadensten & Hagglund 2006, Perese, Simon & Ryan 2008, Stinson 2009). Others report little or conflicting evidence regarding the benefit of using reminiscence with older adults (Lin, Dai & Hwang 2003, Coleman 2005). What is clear throughout the literature is that the outcome of reminiscence is dependent on the techniques used, the motivation of the participants, and the resources available (Coleman 2005).

Older adults experience reminiscence in different ways and as already suggested it may or may not have beneficial effects (Lin et al. 2003). In a study with eight older people, to investigate their experiences of taking part in a reminiscence group, Wadensten and Hagglund (2006) reported that while some participants felt the group was just an activity others in the day-care facility felt it helped them think about life. The convenience sample used by the researchers was predominantly female. The researchers did not predetermine if the participants were interested in reminiscence prior to initiating the study and this may have affected the findings. However, the researchers did develop recommendations for promoting interaction and reflection, that could be used for the organisation of reminiscence groups. Likewise, in a review of the literature on structured reminiscence groups, Stinson (2009) found that it was often difficult to maintain group members. There were high attrition rates reported in several of the studies reviewed and it was found that unless the facilitator was skilled in working with people who had diminished capacity people with cognitive impairment found it difficult to participate. The researcher

however, did offer recommendations for a structured group process and outlined the benefits in terms of psychosocial health of participation, such as decreased depression for older people.

In a qualitative study with 14 participants who had dementia, Surr (2006) using unstructured interviews and an interpretative biographical method of analysis, found maintaining a sense of self was dependant on creating and retelling stories of significant life experiences. The study outlined the importance of helping older people with dementia to continue generating life stories and retain their storytelling abilities. These findings are similar to those of Hyden and Orulv (2009) who used a case study approach to investigate the experience of narrative identity in Alzheimer's disease. The researchers found that while it was difficult for the participants to organise their stories into a temporal ordered narrative, recognising and supporting them to recount their stories enabled the values and norms of their identities to be recognised. Furthermore, the stories we tell are often told in order to give the listener insight into who we are as people and our standing in society. In this case study, Hyden and Orulv (2009) identified that residents with Alzheimer's disease often tell repetitive stories, they surmised that repetition or replaying significant events engaged the listener and confirmed the identity of the teller. The findings of these two studies support the view that narrative approaches to care can have beneficial effects for patients, both in maintaining identity and valuing their ideals.

Canadian researchers, investigating narrative therapy with 12 older adults who were experiencing mental health and substance abuse problems, found a narrative approach to group therapy offered mutual aid to the older people in the group (Poole, Gardner, Flower & Cooper 2009). In group therapy sessions over eight weeks, Poole et. al. (2009) revealed befriending, guilt, power, holding on, and acceptance as key themes. These researchers explained how the power of narrative in both telling and listening can influence healing and empowerment of participants. While the research was limited in its generalisability, and did not have a wealth of research based evidence to support the author's claims, there was value in the anecdotal evidence of increased satisfaction and increased quality of life from the participants. This was because it described the feelings of the participants regarding the narrative approach. However, several limitations of the study

emerged, such as the interruption of the sessions by one of the participants, resistance and the view by others that the group was not beneficial. These limitations highlighted the difficulties encountered in working with groups with diverse needs and also highlight that narrative therapy and narrative approaches may not be beneficial for all patients (Poole et al. 2009).

Memories and autobiography are intertwined (Singer, Blerim & Baddeley 2007). By sharing self defining memories (SDM) individuals create opportunities for positive engagement and reciprocity. In a study to examine if the SDM of older adults match those of adolescents, Singer et al. (2007) found that older adults' memories were more vivid and they were able to recall memories more distant for their current age than were adolescents. The researchers used the self defining memory task and self defining memory rating sheet with their sample of college students (N=49) and older adults (N=44) to examine self defining memories in four dimensions, specificity, affect, integrative meaning and content. The older adults' memories had more meaning than those of the college students and they were better able to connect to their memories. However, the older adults recalled fewer specific memories and their recall was more generalised. While the study highlights the importance of life review therapy for older adults in maintaining their existing abilities and the benefits of reflection there were several limitations highlighted. For example, the sample of older adults was predominantly female and the questionnaires were completed under different circumstances by the two groups. Both of these factors could have contributed to the results obtained; having a different sample or ensuring that the questionnaires completed under similar conditions may have yielded different results (Parahoo 2006).

Narratives and Person-centred care.

Person-centred care needs to be set within the situation of the patient and the culture of the organisation (McCormack & McCance 2006). Person centred caring involves being interested in the experiences of the patient (Price 2006). A person centred approach not only defines what nurses do but also what they should do (Bolster & Manias 2009). Nurses have to be careful not to impose their values and beliefs on the patient but rather to enable the patient recognise their own values and beliefs (Hughes, Bamford & May 2008). Person-centred care is about understanding the meaning patients give to their own life experiences. One way of

understanding is to invite patients to share their experiences through narrative (Price 2006). Narrative can be oral or written. Oral narratives differ from written narratives in that oral narratives enable a dialogue to occur between the narrator and listener whereas a written narrative the reader may be distant from the writer and therefore a dialogue may not take place (Paley & Eva 2005). The patient in a person-centred relationship is able to confide in the nurse in a mutually reciprocal way and develop a relationship that promotes trust and engagement (McCormack & McCance 2006). Person centred care has to be able to adapt and compromise in an ever changing environment of cutbacks and lack of resources. It must also encompass the whole multidisciplinary team (Leplage, Gzil, Cammilli, Lefevre, Pachoud & Ville 2007).

Heliker (2007) in a study to determine if a story sharing intervention could increase the reciprocity between residents and nurses aides (NAs) found that narratives help increase the communication between carers and residents, cultivated a caring empathetic environment, and promoted engagement. Using a mixed method longitudinal study in six nursing homes, Heliker (2007) employed a story telling intervention to help develop relationships between nurses' aides and residents. The aides reported knowing the resident's story encouraged interaction and promoted care that was both meaningful and reciprocal. In a follow up study to investigate the types of relationships residents have in long-term care, Heliker (2009) described 9 patterns and 25 themes to depict how nurses aides (NAs) and residents interact every day. Using phenomenological in-depth interviews with 84 NAs and 54 residents over a six-month period, Heliker (2009) explored the perceptions of the NAs regarding their involvement in a story sharing intervention and the residents and NAs perceptions of their social interactions with one another. Using an iterative process based on Heideggerian hermeneutic phenomenology, the researcher found promoting meaningful engagement between residents and staff increased residents' quality of life and quality of care. Both of these studies, Heliker (2007, 2009) helped NAs identify poor practices and develop a better understanding of the residents. Heliker (2009) is similar to a study by Hellizen and Aspuland (2006) who found that the resident's description of their life story was an important aspect of the caring relationship. Ignoring residents' life stories or looking at them in a superficial way can lead to misinterpretation and ineffectual caring relationships (Hellizen & Aspuland 2006).

Conclusion

Narrative and biography give us an insight into what is unique about the person. The process of telling one's story can often have a therapeutic effect for people. It assists staff to understand the patient's family background and the reasons behind certain behaviours that challenge their ability to care for that patient. Narrative has been used effectively to describe the illness story of patients and with older adults in reminiscence therapy. Studies in the US have found that story sharing interventions have improved the knowledge that staff have about the older person and promoted engagement and caring relationships.

This literature review has highlighted the importance of narrative in healthcare and in promoting engagement and interaction between staff and residents. It further highlights how using narrative in a limited way is not effective or beneficial. This review provides support for the need for a more integrated model of care that utilises biography in both planning care and in promoting a culture of person-centredness. The next chapter will provide an account of narrative theories that, along with person-centred and practice development approaches, will further support and reinforce the need for adoption of an integrated approach to care. This doctoral study aims to build on a co-constructed experience in order to assist nurses with understanding the lived experiences of older adults living in residential care settings.

Chapter 4 – Philosophical Perspectives and Theories Underpinning the Study.

Introduction

The popularity of narratives in social research is evidenced by the abundance of literature available examining the topic (Denzin 1989, Mishler 1991, Riessman 1993, Polkinghorne 1995, Clandinin & Connelly 2004, Barrett, Borthwick, Bugeja, Parker, Vis & Hurtworth 2005, Labov 2006, Clarke & Warren 2007) and by the number of research studies undertaken focusing on both narrative and narrative inquiry (Bluck & Habermas 2000, Kelly & Howie 2007, Hyden & Orulv 2009, Phoenix et al. 2010). This study, with its focus on the developments and evaluation of a narrative based approach, is underpinned by theories of narrative inquiry, person-centred care, practice development and action research. It is also guided by the philosophical perspectives of Heidegger (1962) and Habermas (1984). This chapter outlines the theoretical framework used to guide the operationalisation of a narrative based approach to practice development and will discuss the philosophies of narrative, person-centred care and practice development that underpin the present study. Finally the interrelatedness between narrative inquiry, person-centredness and practice development and the justification for the utilisation of this approach will be discussed. The chosen methodology of action research chosen in this study will be discussed in Chapter 5.

Theoretical Framework



Figure 1 Theoretical Framework underpinning the study

This study is underpinned by theories of narrative inquiry, person-centred care and practice development and guided by the philosophical perspectives of Heidegger and Habermas. Narrative is the overarching paradigm of this study, it underpins the approach used in both the development and implementation of the methodological framework, and informs the ongoing and the over arching analysis. Therefore, the foundation, structure, context and use of narrative in analysis will be explicated in this section. Narrative inquiry provides a unique opportunity for understanding residents and how 'being a resident' impacts on their quality of life. It is a qualitative method of research that attempts to understand how life events have shaped the lives of the residents. There are several theories of narrative and contrary to post structuralists beliefs, narrative theory or narrative analysis cannot be engulfed into one master theory.

Labov (1997) defined narrative structure as abstract orientation, complicating action evaluation, and coda. Structural event according to Labov (1997) is how we organise important events and remember significant life memories. He believes that all or some of these structures are needed in order to analyse narrative. However, in order for a complete picture of narrative to emerge, it is necessary to take several different theories into account. Narrative inquiry is based on literary theory that describes stories as having coherence and three dimensions, temporal, personal and experiential. Coherence is the content of our narrative and how we place it in context. Temporality is an awareness of time and how we experience it. Personal is based on self-defining memories that place emphasis on specific themes and metaphors to give meaning to and organise the personal story (Gaydos 2004). Experiential narratives are based on the human experience of the teller, they can become part of consciousness, and often express and represent a life turning event (Squire 2008).

Both person-centred care (PCC) and practice development (PD) underpin the development of the framework and the implementation of the framework in practice. Person-centred care and person-centred approaches place the person at the centre of care and sees them as individuals. It is based on providing respectful, dignified, and holistic care in an environment that values the contribution and ideas of all those who work and live there.

Developing practice is key to organisation change and has been defined by Hynes (2004) as the "continual questioning of practice". Practice Development promotes the development of skills and knowledge of practitioners and can lead to culture change (Garbett & McCormack 2002). For PD to be successful, it needs to take a collaborative approach, that is based on teamwork and values the contribution of both the healthcare workers and service users (McSherry 2004).

The three elements, narrative, person-centredness and practice development are interlinked in this study as illustrated by the arrows in the model (Fig. 1) that represent movement and interaction between the elements. This will be further explicated in the section on the linkage between them below prior to explaining the theoretical foundations of each of the elements.

How are narrative approaches, person-centred care and practice development linked?

Both person-centred care (PCC) and practice development (PD) have been linked in the literature for a number of years with many writers outlining their interdependent relationships and often hypothesising that one cannot be implemented without the other (Manley et al. 2008, Dewar & MacKay 2010, McCormack et al. 2010, McCormack & McCance 2010). Indeed their symbiotic relationship has been well defined in a number of studies that have used these methodologies as theoretical underpinnings or frameworks on which to pin the research approach (Eve 2004, Lamont, Walker & Brunero 2009, Brown & McCormack 2011, McCormack et al. 2010). McCormack (2004) in an editorial for the Journal of Nursing Research goes so far as to declare the central focus of PD as “the development of increased effectiveness in person-centred practice”.

So how does a narrative approach to care fit with the PCC and PD approaches and is there room for it within these reciprocal concepts? One could argue that narrative not only connects to sociology, literature, and history (Richardson 2000), but the tenets of narrative as outlined below, also connect it to practice and by extension to person-centred care. Narrative has been described as “the primary schema through which human experience is made meaningful” (Polkinghorne 1988 p.125) and is a way of maintaining and creating order out of experience. It also links the individual to his or her context. Therefore, how people become who they are is because of the way they have engaged with the contexts they have been part of (McCance, McCormack & Dewing 2011). These contexts are constantly changing and this affects the way persons learn. Central to the Person-centred Nursing framework is knowing the self and by extension knowing others. It involves knowing the values of the patient but also being clear about one’s own values and beliefs. Similarly, narrative approaches promote a culture of caring because they value the voice of not only the storyteller but also that of the listener/reteller (Bochner 2001). Knowledge i.e. narrative knowledge, can promote a more caring relationship where the narrative can influence the way care is carried out or planned. Narrative deals with meanings, contexts and perspectives and this is similar to the PCN framework that enables understanding. It privileges a person-centred approach by making the person and their story central to the event.

Narrative requires interaction, collaboration and connectivity. In many ways this mirrors practice development approaches and in particular emancipatory PD approaches that aim to promote collaboration, inclusion and participation. If we believe that “all human action is dialogic in nature” (Bakhtin 2010) then surely there must be a place for narrative within a practice development approach which by definition aims to promote authentic engagement (Manley, McCormack & Wilson 2008). Frank (2000), Kleinmann (1988), and others consider narrative as a means of being with others. This involves having an understanding of and ability to identify with the individual and the ability to be empathetic and caring toward that person. This mirrors a PD and PCC approach which promote being in relation (having a good interpersonal relationship, valuing the self and others), being in social context (identifying and linking to things that are important in the context of the world the person lives in), being in place (identifying and working with organisational influences), and being with self (being aware of personal values in order to understand the values of others).

Narratives bridge the gap between what is known and how to apply that knowledge (Kalitzkus & Mathiessen 2009). Narratives have the potential to promote self-reflection and aid professional development through enablement of reflexive practice. Combining PD, PCC, and narrative can potentially enable a more comprehensive approach to the development of an effective workplace culture where the communication qualities of narrative such as active listening, open questioning, and exploration are combined with the principles of engagement, enlightenment, and emancipation to promote person-centredness.

Using a narrative based approach to implement PD could help nurses gain a deeper understanding of the life world of older adults. Combining Person-centred Care, practice development and narrative may enable nurses to assess, plan, implement and evaluate care utilising narrative approaches to provide more holistic care. Implementing the approaches outlined in this theoretical framework can help nurses operationalise PCC in a storied way. According to Habermas (1984) human beings have a desire for unconstrained understanding. Critical reflection and the action that is based on that reflection leads to emancipatory interest. In this research study, will take account of Habermas' (1984) theory of communicative action under an emancipatory practice development approach, using reflection in and on action, to

reach a common understanding and to collaboratively coordinate actions to operationalise a narrative based approach to care.

Narrative Foundation

Many disciplines have influenced the development of narrative as a respected means of inquiry (Gale, Michell, Garand, Williams, Rickman & Bryan 2003). Originally the study of narrative was underpinned by a hermeneutic philosophy which sought to find the hidden meaning of written stories. Recently oral stories have been the focus of investigation but hermeneutics remains central to all narrative inquiry (Wikilund, Lindholm & Lindstrom 2002). This is based on how the narrative is created and how the lived experience is explicated (in language).

Narrative theory suggests that stories have patterns or forms. Texts from similar disciplines have similar characteristics, i.e. the characteristics of a folktale are different from the characteristics of a love story. Propp (1968) identified 31 elements that must occur in order for a story to be considered a folktale. Similarly a love story must follow a set of prescribed characteristics in order to be considered a love story. The way in which the elements of a story relate, shapes the way the listener interprets the story and how they apply that interpretation to their social reality. Heidegger (1962) describes this as the meaning of being or existence. He believes we can only know about people or things by knowing the 'being' or 'nature' of these entities. According to Heidegger (1962 p.201) 'human existence is hermeneutically meaningful' and narrative is the primary schema through which hermeneutic meaningfulness is manifest. Polkinghorne (1988) building on the teachings of Heidegger proposes that individual sentences grouped together do not necessarily create meaningful discourse. However when sentences have a connection and produce meaningful understanding they form a text or a discourse of 'narrative meaning' (Polkinghorne p.32):

“narrative is one of the forms of expressiveness through which life events are co-joined into coherent meaningful unified themes”

(Polkinghorne, p26).

In his book 'Being and Time' Heidegger describes the essence of being, 'Dasein', as existence, facticity and falling. For Heidegger, Dasein is open to the world, in the world and defined in relation to the world. This essentially means according to Heidegger that beings have and are shaped by their experiences. Existence or the

lived experience is defined as a bodily agent who is vulnerable, has a relationship with the world, exists in time and has minimal control over its morality. Being is paying attention to and interpreting events, taking account of what happened in the past, what is happening now, and what might happen in the future. Heidegger (1962) believes that narrative is the representation of human experience as described in terms of time or temporality. In contrast to Husserl who sought to explain experience in a structured linear way and saw time as 'extended awareness', Heidegger believes there are several different layers of time all existing cohesively. Essentially the three elements of Dasein (existence, facticity, falling) are related to an aspect of time (past, present, future) and this is unified or brought together in one authentic self where our past and potential future experiences influence our way of being.

“The study of narrative meaning is to make explicit the operation that produce its particular kind of meaning and draws out the implication this meaning has for human existence”. (Polkinghorne p.6 1988)

The following section on narrative will discuss structural event and coherent experiential narratives. It will outline the context of narrative and discuss narrative analysis and narrative analysis frameworks.

Structural Event Narrative

Narrative has been described by Labov and Waletzky (1967) as a theory of causality. Labov and Waletzky developed their theory of what narrative is from their work with African American's in Harlem in the 1960's and 1970's. They believe that an event can be judged by the way it is told and that the unfolding of that event is in fact the theoretical foundation of the event (Mishler 1991). Labov and Waletzky (1967) conceptualise narrative as a personal event that reiterates an experience in an ordered sequential manner and that matches the event with the story (Squire 2008). Labov (1997) describes this narrative framework as having a definite structure that encompasses abstract, orientation, complicating action, evaluation, and coda, and later added resolution (Labov 2006). According to Labov (2006) a narrative may contain all or some of these stages but may not outline them in this sequential order. The abstract is the initial group of words that describes the order of the narrative or that grabs the attention of the listener. Orientation is the point of reference that explains where the narrative takes place, who the actors are and how

they behave. The complicating action is the event that moves the narrative forward. Evaluation refers to the reason the narrative is being told whereas resolution is the end result of the telling or the close of the narrative. Lastly the Coda is where the narrator connects the narrative to certain events that fall outside the story being told or to life in general. This stage may or may not be present in the narrative (Labov 2006).

Mishler (1991) believes that Labov and Walsetzky (1967) were the first to apply the definition of narrative structure as encompassing abstract, orientation, complicating action, evaluation, and coda to narrative and narrative interviewing. Their aim was to present a temporally ordered framework that would see the narrative as a sequence of speech clauses that relate a sequence of events. Labov and Walsetzky believe if the sequence of clauses is altered the meaning of the narrative is altered too. Labov and Walsetzky (1967) applied this framework rigorously to their analysis of narrative interviews; other researchers however, found this difficult to replicate. Labov (1982) addressed this by stating that rather than capturing narratives meaning by temporally relating speech to action it should be “illuminated” through personal narrative. This is, that the analysis should be focused on the way in which events function in the lived world of the narrator (Squire 2008). This alignment enabled Labov’s work to be more closely related to that of traditionalist researchers who believe that narrative can be analysed either wholly or in part and that the analysis does not necessarily have to rigidly follow a specific structure but should encompass the meaning of what the narrator is trying to say and more importantly the context in which they are saying it (Chamberlyne, Bornat, & Wengraf 2000, Riesmann 1993, Ricour 1991, Denzin 1989).

Labovian methods of narrative analysis are still useful in narrative research (Squires 2008). They provide a platform for commencing analysis and are a particularly potent tool for explicating key life moments (Denzin 1989). However the rigid approach of this method of narrative research does not allow for what Heidegger calls “temporality of being” where the very nature of existence and experience is enveloped in our understanding of our place in time having knowledge of where we have come from and where we are going.

Structural Event Narrative and Temporality

Ricoeur (1985) expanded on this work in his *Narrated Time and Narrative Series* (Vol. 1, 11 & 111) and posits where the person is in time affects who they are:

“Temporality is the articulated unity of coming towards – having been – and making present” (Ricoeur 1985, P.70).

He further believes that our past experience of 'being in the world' and our place in time shape how we express our narrative, because of this our account is at best semi-fictional. Time can be conceptualised as a linear event that has a chronological order and that occurs even if someone is not experiencing it (Cunliffe, Luhman & Boje. 2004). Husserl (1991) explained that narrative time is different from ordinary time. Ordinary time is defined as the time between two points, whereas narrative time is the awareness of the past and how we remember it, the future and what we expect to happen and the present and how we are in the moment. According to Ricoeur (1985) 'time is experienced subjectively and narratives are spontaneous acts of meaning making that take place and interweave through many moments of discursive time and space' (p.262). Ricoeur's hermeneutic framework is based on the way the narrative interacts with life events and on his interpretation of the works of Aristotle, Augustine, Kant, Husserl, and Heidegger. Ricoeur believes that life events come before a narrative and that narrative explicates how we intend to take action. This is in line with both Heidegger and Polkinghorne's views on narrative meaning and while the approach is valid, it fails to take account of either the content or the context of the narrative, both of which are outlined below. According to Ezzy (1998) factual events of the lived experience are shaped into flawed stories that inform actions which in turn become narratives. Thus the process of 'living', storying that life and 'reliving' is a circular process which according to Ricoeur (1985) is one of multiple understandings.

Coherent Experiential Narratives.

Coherent experiential narrative builds on structural event narratives and expands the idea of sequence and meaning. Specifically, this type of narrative research focuses on the content of the narrative and aims to give a fuller hermeneutic interpretation of the story as distinct from Labovian structural event narrative (Mishler 1991). Coherent experiential narrative according to Squire (2008) is the prevailing method of narrative research currently being employed by the social

sciences. Experiential or experience narratives offers more flexibility with regard to both time and place, and are not limited by their applicability to structure (Denzin 1989). This narrative can focus on important experiences of a person's life such as being admitted to residential care or to the entire story as it is related to the researcher (Riessman et al. 2007). Meaning, in this type of narrative, is often situated in the interaction between the narrator and the interviewer (Squire 2008). Paul Ricoeur (1991) in his work entitled "Life in Quest of Narrative" attempts to relate life to narrative and he conceptualises narratives as only having meaning when they are heard and when they are coherent. He also states that narrative and narratology are an interactive process where the narrator is aware of the interviewer; this awareness can shape the way the narrative is told (Ricoeur 1991).

Mishler (1991) outlines the value of co-constructed meanings of narrative; that is, one that is arrived together by the researcher and narrator. Mishler (1991) cautions however, that researchers must pay particular attention to the 'discursive nature of narrative'. This attention, according to Colombo (2003), has important implications for the way researchers analyse narratives. That is, the account related may have several different versions and researchers must be careful not to apply their version of what they believe is real. Researchers need to take into account the possible realities related by the narrator.

Riessman (1993), in her study of infertility and stigma among South Indian women, revisited the data with her participants in order to assess if she had correctly interpreted their contribution. The participants confirmed the interpretation as a true representation of their stories, however, Riessman (1993) cautions that the validity of this method may be uncertain. That is, she believes that participants may find it difficult to interpret theorizing that takes place across a number of different narratives. She further advises that researchers must be prepared to take responsibility and ownership of the work as it is the researcher who has carried out the analysis. While Riessman (1993) encourages researchers to share their findings, she does not insist that they do so. She believes that the way in which researchers interpret the narrator's dialogue can determine what is and what is not seen as coherent.. Ager and Hobbs (1982) describe three different kinds of coherence, global, local and themal. Global coherence refers to the point the narrator is trying to make, essentially the story the narrator is trying to tell. Local

coherence is the relationship between what is being said to other sections of the text. Thematic coherence is what is being said repeatedly throughout the text. According to Riessman (1993 p.67), 'investigators must continuously modify initial hypotheses about speakers' beliefs and goals (global coherence) in light of the structure of particular narratives (local coherence) and recurrent themes that unify the text (thematic coherence)'.

Polkinghorne (1988) building on the work of Heidegger believes there are five problems that arise when someone is trying to study meaning in narrative.

1. Meaning is difficult to measure and quantify as it changes constantly in accordance with our perceptions and interpretations of it.
2. The activity of meaning making involves reflection which may change the meaning by forcing us to recall something that normally takes place in our subconscious. However we may only have access to the outcome and not the process as they may be repressed by our subconscious.
3. Narrative has to use language to make sense of meaning. Both language and meaning have structures. Meaning uses linguistics to make sense of it,, if we study it in isolation this can become a problem as meaning is 'context sensitive'.
4. Analysing meaning involves the use of hermeneutics which can interpret what the narrative is, but cannot give definitive quantifiable data.
5. Meaning is the collection of memories, beliefs and fantasy we have limited control over how these three elements interlink, because of this meaning is very difficult to interpret.

Narrative according to Polkinghorne (1988) is essentially a way of knowing that has a particular form and account needs to be taken of the above problems in order to arrive at an explanation of the experience under investigation.

The current study will take a coherent experiential approach using the philosophies of Heidegger, Ricour and Polkinghorne, as outlined in the theoretical framework at the beginning of this chapter. It will also take account of the context of narrative as explicated below.

Context of Narratives.

Context, an important aspect in narrative research, is often overlooked. Stories are strongly influenced by the circumstances of the narrator and by the context in which they are situated (Squire 2008). Both Mishler (1991) and Riessman (1993) included the context of their research subjects and also take this into account when analysing their data. Riessman (1993) situated her respondents in a cultural context that values family and stigmatises infertility. By doing this, Reissman allows us the readers, to gain an understanding of the differences between the respondents' culture and the one where we may reside. Reissman also explored the expectations and the roles assigned to particular members within a specific culture. This inclusion of contextual circumstance has implications for the way respondents tell their story and Reissman addressed these implications in her analysis. For example, Gita the narrator, situates herself within her narrative, the analysis of her narrative takes account of a culture that places a high value on fertility and devalues infertility. Conversley, despite Squire (2008) situating her study within the contextual genre of HIV positive people in South Africa, she cautions against the over reliance on this method of narratology as it may lead to losing sight of the individual story within the broader cultural context. Squire (2008) believes that we should not totally discount the contribution of culture and context in narrative research, but use it cautiously as it can have a catalysing effect on accepted social mores and political structures.

Narrative Analysis

Narrative interviewing enables the interviewees to express their views by telling a story. They can do so in their own language describing what they believe is significant. These Interviews according to Rapley (2004) are jointly agreed versions or accounts of events or experiences that are produced collaboratively by the interviewer and interviewee. Rapley (2004) further believes that the context of the interview is important and should not be discounted when analysing the interview content. That is, the place where an interview occurs or the situation the interview is seeking to address is as important as the interview itself and should have an impact

on how the interview is analysed (Rapley 2004). The interviewer needs to listen to the type of language the interviewee uses to ensure they understand the topic under consideration. The type of language used by the researcher can either promote or hinder communication (Bates 2002). Narrative interviews allow both the narrator and the interviewer to make sense of and develop an understanding of the conversation together (Kelly & Howie 2007).

Analysing narratives helps us to develop a deeper understanding of the events being explained (Frid et al. 2000). For example, there is a need for analytical multiplicity when analysing narratives. That is, this allows the researcher to delve into different components within the narrative and create a better understanding of the social world of the narrator (Phoenix et al. 2010). There is no best way to perform narrative analysis, however the strength of a robust analysis is that it focuses on what is told and how it is told (Riessman 1993). Most forms of analysis focus on the whole story and not on the individual components of the story. The researcher conducting the analysis is concerned with understanding the way in which people describe where they are in the world, how they logically describe their current situations, and how they interact socially (Polkinghorne 1995).

Narratives depend on certain constitutions to hold them together and most researchers call this plot (Hyden & Orulv 2008). Therefore, the researcher needs to search for plot, patterns and breaks in the narration. In story analytic technique, the researcher analyses the story for certain features and links these to a theory or develops theoretical abstractions from these links (Phoenix et al. 2010). These researchers believe that the story is the analysis and the people who are telling the story are employing analytical techniques to frame their story (Phoenix et al. 2010). Some researchers use this structural analysis to determine the values and beliefs of the storyteller, however it is rare for researchers to solely rely on this type of analysis. Phoenix and Sparkes (2007), however, are an exception to this rule. These researchers use structural analysis to describe how people belong to a specific narrative cultural group and how their narratives are informed by the identity of the particular group they belong to. There are however, several problems with this type of structural analysis. For example, it is not useful for large samples (Riessman 1993). In addition, it is difficult to make generalisations across several different cases and the subjects are often drawn from unrepresentative pools.

While Riessman (1993) freely acknowledges these limitations she nonetheless advocates for narrative to be used as an approach for investigating the meaning of personal experiences.

Narrative analysis takes as its object of investigation the story itself. According to Riessman (1993) it opens up forms of storytelling about experience. The construction of meaning through narratives seems to be a fundamental aspect of both individual and social experience (Andrews 2002). Merleau Ponty (2002) believes that language and thought must be connected to life experience in order to be meaningful and that the hermeneutic relationship between life and story is essential. Story shapes and gives meaning to life just as life and life experience are the building blocks of story. In this study, the terms story, narrative, history and biography are used interchangeably because practitioners and residents use all of these terms to mean the same thing. Narrative is used descriptively in everyday language to describe story much as it is used in academic language within the humanities to describe written, verbal, visual or auditory language. For this reason and also because several researchers (Riessman 1993, Andrews et al, 2004, Squire 2008) have also used these terms interchangeably in their writings, I will also use these words interchangeably in the current study.

Definitions of narrative vary considerably and are usually particular to the discipline being researched (Riesman & Speedy 2007). For example, these definitions refer to life story, world views or historical accounts, and they are evolving and unrestricted. At the other end of the spectrum are what Labov (2006) calls discrete units of discourse, that are structured and temporally ordered. Somewhere in the middle is the type of narrative associated with psychology where interviews with clients illicit long sequences of talk that identify the life of that person in the context of where they live (Riesman & Speedy 2007). While there are several competing and differing definitions of what encompasses a narrative or a story, what is common to all is their intention to provide meaning to human existence. This in essence means that a resident reflecting on their life story will give an account that has significant meaning to them relating a story that is both meaningful and pertinent (Collingwood 1993) with essential elements that do not change. The person's past can be understood by someone living in the present because it is being viewed from a distance, the person is able to distinguish the important or salient aspects of their story and relate

while filtering out the unimportant, non-essential elements. Derrida believes the telling of a story is a set of disparate experiences that the teller attempts to bring together by repressing or omitting elements that do not fit. This according to Derrida, as cited in Lai (2010), brings the life event into a new framework of associations. Alternatively, Gadamar's (1995) theory of interpretation disagrees with this and states that by trying to explain what the important aspect of our life is, we in effect 'change our life'. Narrative researchers interpret narrative in 2 contexts, the context in which the story is told and the one in which it is lived. They work with both explicit and tacit information. In order to fully understand the raw data narrative researchers must reconceptualise the data in order to gain a new understanding of the life event (Lai 2010).

Frameworks for Analysing Narratives.

Narrative frameworks are useful in order to allow practitioners access to the experiences of patients (Kelly & Howie 2007). These frameworks rely on the persons desire to tell their tale. Combining stories gives deeper insight into the culture and context of where these stories are set and enables the researcher develop a shared meaning of what the communal lives of these participants is like within the communities where they reside. There is no one set method for analysing narratives (Riessman 1993). In fact, several different frameworks for analysing stories have been used in narrative analysis (Riessman 1993, Polkinghorne 1995, McCance et al 2001, Bates 2002, Kelly & Howie 2007) and researchers have often adapted frameworks to suit their purpose (McCance et al. 2001, Kelly & Howie 2007). Analysing stories is mostly shaped around either paradigmatic or narrative analysis. While paradigmatic analysis is a structured and formal method of analysis, narrative analysis is less formal and often provides more insight into the lives of the people under investigation (Riessman & Speedy 2007). Narrative analysis according to Jovechelovitch & Bauer (2000), describe three elements. These are the basic structure of the narrative, (characters, plot, actions and time sequence), where the narrator places themselves in the world and the closing of the Gestalt. This means it must have a beginning, middle and end. Riessman (1993) describes six elements necessary for narrative analysis to be complete, these include, a synopsis, a point of reference, an action, an appraisal, a summing up and a relating back of the narrative to the present. Denzin (1989) believes that 'each narrative has described a sequence of events that have happened'. What these methods of

narrative analysis have in common is that they all in some way describe narrative analysis as having a beginning, middle and end, are rooted in time, place and populated with actions, have a central theme or plot and make sense to the story teller. The stories in this study, both those used in the narrative analysis and those told by participants in the work-based learning days, were chaotic. They described living and working in the setting in a stream of consciousness way with little concern for a logical beginning, middle and end. However, they were all based on the elements of narrative as outlined about albeit in an illogical order and they did all make sense to the tellers. To facilitate the analysis of these narratives in both the secondary data analysis section (Chapter 5) and in the evaluation section (Chapter 8) these stories were reconceptualised to flow logically into beginning, middle and end elements, using the told or written narratives as described by Jovechelovitch & Bauer (2000). This enabled the voices of the residents and the care staff to be heard and taken account of the development of the Framework of Narrative Practice, the analysis of its implementation in practice and the overarching evaluation of the study.

While narrative inquiry is the overarching paradigm of this research, operationalising this approach will also take account of person-centred and practice development approaches.

Person-centredness

As discussed previously, person-centred care has become the buzz word for policy makers who brandish the term widely in an effort to produce policy documents that adhere to government guidelines and that are attractive to funding agencies; requiring care to be prescribed as holistic and inclusive.

The concepts of person-centred care currently expounded in the literature are derived from the Rogerian model of counselling which is based on the assumptions that each person is responsible for their own choice and decisions (Lane 2000) and that care is a mutual relationship between the patient and the carer that is built on trust, understanding and respect (Binnie & Titchen 1999, Barker 2000, McCormack 2003, Nolan et al. 2004, McCormack & McCance 2006). There are many models of person-centred care in existence and recent studies have begun to explore their use

in practice (McCormack et al. 2010). Their effectiveness, however, has not been fully tested, which may limit their application (Dewing 2004).

In 2007, Brooker expanded on Kitwood's (1997) ideas of person-centred care for people with dementia and developed the VIPS model of dementia care. This model is comprised of four elements. They are:

- V a value base that asserts the absolute value of all human lives regardless of age or cognitive ability.
 - I An individualised approach, recognising uniqueness
 - P Understanding the world from the perspective of the service user
 - S Providing a social environment that supports psychological needs.
- (Brooker 2007, p13)

Brooker (2007) offers this model as a framework to enable people working with individuals with dementia to provide care that is both person-centred and systematic. Building on both the work of Kitwood (1997) and Brooker (2004), Burrton (2008) proposes a personhood model of dementia care that is based on three levels of personhood:

- Biologic personhood
- Individual personhood
- Sociologic personhood

This model is based on relationship-centred care where the first level of personhood is the recognition that the basic biological needs of the person with dementia must be addressed. Once these needs are met, it is then possible to actively interact with and provide social activities that take account of the individuality of the person. By obtaining and acting on both biological and individual information, the carer is able to ensure that the person with dementia is able to engage in a socially appropriate way. Most person-centred literature that focuses on dementia care tends to discuss the nature of person-centredness in relation to the behaviours exhibited by the person with dementia and the responses to this behaviour. While it is important to acknowledge that behaviours can have an impact on the personhood of the patient, interaction based on this definition can lead to hierarchical or paternalistic views of what person-centred care is and have a danger of being more about the personhood of the person responding to the behaviour than the

personhood of the person exhibiting the behaviour. Sixty seven per cent of the residents on the research site, of the current study, have some form of cognitive impairment and it was therefore necessary to take this into account during the study.

One of the theoretical frameworks underpinning this study is the person-centred nursing framework (McCormack & McCance 2006). Both caring and person-centredness have their roots in the human sciences and like the theories of Watson (1988), Parse (1981) and Neuman's (1982), the value of putting the patient at the core of the nursing intervention is espoused. Caring in nursing has traditionally been seen as central to nursing care and person-centredness. Caring requires the formation of a therapeutic relationship between the carer and the patient, which makes the central aims of both these frameworks compatible. Similarly both caring and person-centredness deal with nursing attributes, environmental/organisational factors, and patient traits (McCormack & McCance 2006).

The person-centred nursing framework (McCormack & McCance 2006) is built on four pillars, these are the foundation of the framework and it is by working through each of these pillars or constructs that person-centred care can be achieved. The constructs are (1) prerequisites, (2) the care environment, (3) person-centred processes and (4) person-centred outcomes (McCormack & McCance 2006). Prerequisites are the qualities ascribed to and based on the professional expertise of the nurse. For McCormack and McCance (2006) in order for genuine person-centredness to occur nurses must be professionally competent, have good interpersonal skills, be aware of and able to describe their values and beliefs, be committed to their job and also know themselves. Knowing the self, according to Freshwater (2002), is essential to developing caring relationships that are therapeutic and that are needed for the development of honest open relationship with others Cook (1999). While McCormack & McCance (2006) use the words person-centred nursing to describe their framework it is clear that the elements of the framework can apply to all healthcare staff. As all staff working in the residential care setting were involved in the present study, the terms person-centredness and person-centred care will be utilised throughout this study when discussing the way care was carried out. By using the prerequisites, as described in the person-centred framework, nurses and carers can be clear about the values that are important to them while at the same time recognise that the resident also has values that they

feel are important. This recognition leads to a negotiated approach to patient care, which is a central theme in many models of person-centredness (Kitwood 1997, Baker 2000, Titchen 2001, Nolan et al. 2004, McCormack & McCance 2006).

The care environment construct focuses on the setting in which care is provided. It includes appropriate skill mix, shared decision making, effective staff relationships, supportive organisational systems, power sharing and innovation and risk-taking (McCormack & McCance 2006). In a qualitative research study measuring the perceptions of and factors that affected quality of care for older people in long term care, Murphy (2007) found that quality was facilitated in a home like social environment that was person-centred when holistic care was provided by knowledgeable and skilled staff who knew the patient. In order to attain this supportive organisational systems must be put in place (Wilson 2005). These systems include developing a culture where practitioners can learn from their work, having a high level of interaction between patients and organisational management and enabling practitioners to identify and to resolve issues for themselves (McCormack, Manley & Garbett 2004). The care environment construct promotes person-centredness in an environment where culture change is promoted by facilitating transformational leadership, where practice is constantly being evaluated and where the organisation is willing to adapt in the face of that evaluation.

Person centred processes are the components of the framework that link the previous two components and the last component, person-centred outcomes. It can be seen as the lynch-pin of the framework. Person centred processes focus on the interaction between the nurse and the patient, and on the way in which person-centred care is carried out (McCormack & McCance 2006). Emotional aspects of care are also accounted for in this part of the framework. Both engagement and sympathetic presence are included here. According to Bellack (1999) and Fuimano (2004), emotionally intelligent practitioners are more connected and authentic. By reflecting on their practice, nurses are able to assess their authenticity. This in turn enables them to engage in a way that recognises the individuality of the patient and promotes their personhood. It is in this construct that the value of narrative and “knowing” the person is explicated. According to McCormack and McCance (2010), when nurses have a true understanding of the biographical details and rich tapestry that make up a person’s life, a reciprocal relationship which allows the patient to

attain their full capabilities can occur. By obtaining the life history of the patient, nurses can attach meaning to both their involvement with care and decisions they make with regard to life or care choices. Information about life history also enables nurses acknowledge that when certain medical or nursing decisions are not having the desired effect, it may be the result of biographical details they were not privy to. By obtaining and incorporating the narrative biography of the patient into their care plan and utilising this information to aid with the assessment, planning, implementation and evaluation of care, nurses can obtain a clearer picture of how the patient would want their care delivered.

The person-centred outcomes are the measurable outcomes of the framework and include satisfaction with care, involvement with care, feelings of well-being and creating a therapeutic environment (McCormack & McCance 2006). While McCormack & McCance changed 'therapeutic environment' to 'creating a therapeutic culture' in their recent publication (McCormack & McCance 2010), the present research study and the framework developed therein was conducted prior to this publication and therefore the original person-centred nursing framework and its constructs were the underpinning framework for this study. It is this original framework that will be referred to throughout this thesis although reference will also be made to the 2010 re-conceptualisation of the framework where appropriate. McCormack and McCance (2010) stated that measuring nursing outcomes can be problematic due to the inability of nursing practice to be matched to specific patient outcomes. They proposed three themes that can be used to measure them:

"Feeling involved with care

Having a feeling of well-being

The existence of a therapeutic environment "

(McCormack & McCance 2010 p. 118)

In addition to the three themes, McCormack, McCance and Maben (2013 p. 200) proposed four outcomes that apply to staff residents/patients and families that could be used to measure outcome evaluation. Specifically these are: "satisfaction with care, involvement with care, feeling of well-being, creating a therapeutic culture" (McCormack et al 2013 p. 200). Furthermore, they advocate that practice developers introduce their own framework for evaluating implementation and outcomes. Therefore, taking a narrative approach and mapping that approach to a

specific narrative framework may achieve this in practice. Nursing's contribution to the care of patients is often difficult to quantify and despite recent developments internationally to identify and to measure nursing outcome indicators, putting a quantifiable measure on nursing care remains complex (Meyer & Sturdy 2004).

In their book, "Person-centred Nursing Theory and Practice, McCormack and McCance (2010) put forward a number of methods that can be utilised to measure these outcomes. These are the workplace culture critical analysis tool (WCCAT) (McCormack, Henderson, Wilson & Wright 2009), the person-centred nursing index (PCNI) (Slater 2006) and narratives (Hsu & McCormack 2006). McCormack et al. (2013 p.7) outline further methods such as developing a shared vision, developing critical intent, facilitating transitions and giving space for ideas to flourish that further add to the systematic approaches utilised to measure practice development outcomes. While these methods have been tested it would be fair to say that their focus on multiple data collection methods would make it difficult for nurses to utilise in practice. This may prevent nurses using them to evaluate if the use of the framework is influencing care of patients in a person-centred way. Both the WCCAT and narratives are easy to collect, can be analysed thematically and the resultant themes utilised by nurses to benchmark if the care they are providing is adhering to person-centred principles as prescribed by the framework. However, the PCNI which requires the collection of data via a questionnaire needs to be analysed statistically and may be too complicated for most practitioners to utilise in practice. The PCNI may only have utility in research. Narratives in particular can be incorporated into the everyday care of the patient and by adhering to a biographical approach to nursing care, nurses can know the patient in an intimate way thus facilitating adherence to person-centred care principles. The information gathered from narratives can also be utilised to measure care provided and to benchmark that care against the Person-Centred Nursing Framework.

The framework has been tested in practice initially in the acute and more recently in long term care settings (McCormack & McCance 2006, McCormack et al. 2010). This continued testing has increased its validity. However, the frameworks relationship to narrative and biography has not yet been determined. The aim of the present study is to develop a framework that contextualises person-centredness and

allows nurses to collect narrative type data to determine where person-centredness is working or where it needs to be developed.

Practice Development

Practice development gained popularity in the 1980s with the establishment of the Nursing Development Units (NDUs) in the UK. The focus of these units was on developing competencies, initiating improvements in practice using innovation and developing clinical leadership among the nurses working there. The explicit aim of these units was to enhance and increase nursing knowledge by evaluating practice and implementing research findings in the practice environment (Pryor & Forbes 2007). As the NDUs evolved so did the concept of 'practice development'.

In a healthcare system that is constantly striving for quality improvement and excellence, practice development has been defined as a “broad based concept encapsulating a wide range of activities aligned to change management” (Unsworth 2000). Practice development is concerned with improving the quality of patient care by ensuring that standards are maintained and adhered to and that professional practice is enhanced (McSherry 2004). In a widely accepted definition of PD, which is underpinned by critical social sciences, Garbett and McCormack (2002) describe it as:

“a continuous process of improvement towards increased effectiveness in patient centred care. This is brought about by helping healthcare teams to develop their knowledge and skills and to transform the culture and context of care. It is enabled and supported by facilitators committed to systematic, rigorous continuous processes of emancipatory change that reflect the perspective of service users .”

p.29.

More recently practice development has been used to show how practitioners describe how specific changes are achieved in healthcare settings (McCormack & Garbett 2004, Manley & McCormack 2004, Manley, McCormack & Wilson 2008, McCormack et al.2010). Aggergaard Larsen, Maundrill, Morgan and Mauland (2005) describe PD as:

“ways in which knowledge and skills development is used to provide better patient care”.

p.143

At the core of these changes is the way skilled facilitation uses creativity to achieve practice outcomes and personal and professional development. Recognising the importance of creativity in practice development and building on Fay's (1987) critical practice theories, McCormack and Titchen (2006) developed a framework to help guide practice developers in using creative methods. This framework integrates practice knowledge, artistic endeavour and critical reflexivity with the ultimate goal of enabling "human flourishing". It could be argued that this theoretical framework is closely aligned to what Finfgeld-Connet (2008) conceptualise as the art of nursing. In this conceptualisation, Finfgeld-Connet hypothesises that nursing is not only concerned with the utilisation of expert knowledge but also with adapting both experiential and theoretical knowing in order to promote personal and professional growth. Finfgeld-Connet (2008) proposes that nurses do this by "the discretionary use of creativity" which seems to gel with McCormack and Titchen's (2006) philosophy of "critical creativity". This increased focus on creativity and the recognition that skilled facilitation is necessary in order for "human flourishing" to occur led to a revision of Garbett and McCormack's (2004) practice development definition

"Practice development is a continuous process of developing person-centred cultures. It is enabled by facilitators who authentically engage with individuals and teams to blend personal qualities and creative imagination with practice skills and practice wisdom. The learning that occurs brings about transformations of individual and team practices. This is sustained by embedding both processes and outcomes in corporate strategy."

(Manley et al. 2008 p.9.)

Manley et al's definition describes practice development as the relationship between practice and professional development, and highlights the importance of ensuring that practice development initiatives are recognised and outlined in the corporate policy of the organisation.

In the first systematic review of practice development (PD), McCormack, Wright, Dewer, Harvey and Ballintine (2007) outlined key recommendations that need to be realised if PD is to be credible. Building on these, Manley et al. (2008) identified nine key principles that need to be in place if practice development is going to be effective. These principles, outlined below, propose to make clear the purpose of PD, they also seek to provide direction and guidance to practitioners wishing to

undertake practice development work. McCormack et al. (2007) believe that utilisation of these principles will adhere to the quality improvement agenda of healthcare organisations. They further believe these principles will enable research that informs practice and sustainable culture change through the use of systematic approaches.

Pryor and Forbes (2007) put forward that practice development is :

“underpinned by an interest in the culture and context where PD occurs.”

This is in line with the first principle of PD as outlined by Manley et al. (2008) and highlights the importance of culture in the PD process.

Box 1 Principles of Practice Development

1. It aims to achieve person-centred and evidence based care that is manifested through human flourishing and a workplace culture of effectiveness in all healthcare settings.
2. It directs its attention at the micro-systems label – the level at which most healthcare is experienced and provided, but requires coherent support from interrelated mezzo-and macro-systems levels.
3. It integrates work-based learning with its focus on active learning and formal systems for enabling learning in the workplace to transform care.
4. It integrates and enables both the development of evidence from practice and the use of evidence in practice.
5. It integrates creativity with cognition in order to blend mind, heart and soul energies, enabling practitioners to free their thinking and allow opportunities for human flourishing to emerge.
6. It is a complex methodology that can be used across healthcare teams and interfaces to involve all internal and external stakeholders.
7. It uses key methods that are utilised according to the methodological principles being operationalised and the contextual characteristics of the PD programme of work.
8. It is associated with a set of processes including skilled facilitation that can be translated into a specific skill set required as near to the interface of care as possible.
9. It integrates evaluation approaches that are always inclusive, participative and collaborative.

(Manley et al. 2008 p.5.)

PD has been described mainly in two ways, technical or emancipatory, however sometimes a mixed approach, (combination of both technical and emancipatory), has been advocated (Tolson,Bennett, Currie, Mohammed & Middleton 2009). While

both technical and emancipatory PD have similarities, according to Manley and McCormack (2004) they are different. Technical practice development (tPD) occurs as the result of a service improvement or patient outcomes using technical knowledge to bring about the practice change. Technical PD is not concerned with changing the culture of the organisation but with implementing the ideas of the practice developer using the staff to effect the change. This type of PD does not encourage the staff to be the owners of the change, but makes the PD facilitator responsible for the change and also responsible if it does not go well. McCormack et al. (2004) believe that adoption of this type of PD does not enable practitioners to demonstrate if they are utilising research in practice as the approach has limited sustainability and practitioners see it as a method that has been implemented in a “top down” approach where they are expected to “do” rather than “own” the change. Technical PD focuses on prescriptive learning for staff that frequently involves training or competency assessment. There is little or no involvement of stakeholders and service users are generally not consulted (Tolson et al. 2009). It is according to McCormack et al (2004);

“a technical instrument for achieving the development of services to patients”

p.36-37

and is usually a *“consequence of practice development rather than a deliberate and intentional purpose”*.

p.36

Tolson et al. (2009) assert that technical practice development models achieve outcomes faster than emancipatory methods, this may be down to their intentional neglect of the culture or context where care occurs, it may also be as a result of organisational punitive measures taken to ensure uptake and sustainability of the change. Webster (2004) further asserts in organisations where “technical” results are valued over transformational ways of working, practice development has decreased effectiveness.

By comparison, emancipatory PD (ePD) is influenced by critical social science (Manley & McCormack 2003), it focuses on recognising the views of staff and services users, using reflective practice and critical thinking to transform workplace

cultures and engages with all relevant stakeholders. Habermas (1984) in his theory of communicative action suggests that we become ourselves by our interaction with others and we adjust how we are by taking account of the reactions of others to us. He believes that actions are something a person does that have a purpose (Habermas 1984) and that knowledge gained by self-reflection is emancipatory. While both technical and emancipatory PD can have an effect on the organisation, McCormack et. al. (2009) would argue that the explicit intent of ePD is the promotion of person-centred care with a focus on the culture of the organisation where that care is occurring, enables practice changes that are underpinned by an ePD methodology to become embedded within the organisation. The driving force of ePD is to provide practitioners with opportunities to bring about transformational change. These opportunities result in practitioners becoming aware of the way they practice, critically reflecting on practice and on themselves, and empowering a practice modification. It is these characterisation that makes ePD distinct and different from tPD.

Page and Hamer (2002) assert that practice development should be “patient” focused and should not be centred around the “professional”. While it is true that the intent of PD is to focus on the quality of patient care and to improve the quality of services (Chin & Totterdell 2009), if the underpinning philosophy of effective PD is a humanistic person-centred one, then the perspectives of the practitioner also require attention. Manley & McCormack (2004) advocate understanding and recognising the beliefs and values of the practice developer as well as the service user. This inclusion along with other key principles as outlined above are the underpinning philosophy of emancipatory practice development activity and lead to sustainable embedded practice and culture change.

There is a need for clarity around the role of PD within organisations. For example, practitioners often face challenges when proposing PD programmes to managers who require specific short-term measurable outcomes. While the purpose of PD is clear (Garbett & McCormack 2002) it is often difficult for practitioners to define it or to explain the underpinning methodological processes. Chinn and Totterdell (2009), commenting on the Darzi Report (2008), believe that teams that are effective at PD utilise a “systematic and co-ordinated” approach. This approach incorporates recognising strategies that are effective, ensures initiatives are evaluated and has

supportive management structures that value practice development in their governance policies. The intent of PD is sustainable culture change. A PD approach does not usually show outcomes in the immediate but often requires a sustainable engagement. Managers who have to show value for input into quality improvement find it difficult to appreciate the value of a PD approach. However, organisations that utilise systematic approaches and guiding principles as outlined by Manley et al. (2008) have shown both immediate and long-term sustainable changes that have become embedded in practice (McCormack et al. 2009).

Several researchers have demonstrated PD's sustainability for example, Dewing (2008), in a review of PD and its implications for nurse managers, states that traditional education approaches appear to have little impact on sustainability or direct impact on practice. She reports that PD approaches of reflective practice, work-based learning and active and action learning can offer more effective ways to ensure that sustainability occurs. McCormack et al. (2009) highlight strategies such as shared ownership, development of self-awareness, dealing with what is important to the ward staff and the enablement of better patient care as useful methods for ensuring the sustainability of practice development initiatives. Eve (2004) describing a four year practice development accreditation implementation in a rehabilitation centre, outlines how PD creates noticeable shifts in care delivery and breaks down traditional views of rehabilitation. The changes implemented in this programme were still visible after the accreditation process had been achieved.

These principles of PD have been tested in a National Practice Development programme in the Republic of Ireland (McCormack et al. 2010). This PD programme was underpinned by the person-centred nursing framework (McCormack & McCance 2006) and an emancipatory practice development framework (Manley & McCormack 2004). Evaluation of the PD programme highlights creative collaborative ways of working, supportive management structures and engagement with all stakeholders as a means of ensuring sustainability of change. The evaluation also highlights that change, that is meaningful, effective and fixed in the care environment is not a once off process but a continuous evolving one (McCormack et al. 2010).

Conclusion

The literature shows that narrative and narrative analysis can address personal issues, social events, it has multi-disciplinary use. Narratives have proven their utility in the literary and the cultural world. They provide a causal connection between a sequence of events and are rooted in temporality. Narrative is the construction of an individual's life history and as such is a combination of all the significant events that occur in that individual's life. Narratives are linked to both time and experience. They are set within a context that has implications for both the way the narrative is told and also how it is understood. Narrative has been widely used in healthcare to describe and give meaning to crisis events such as acute illness, cancer or debilitating illnesses such as motor neuron disease. The advantages of a narrative approach has been well delineated in the literature with researchers promoting its use for the development of nurse-patient relationships, its influence on healing and empowerment of patients, its link with identity and memory and its cultivation of engagement and increased communication. However the main use of narrative in healthcare has been to elicit the experience of patients or healthcare workers to a particular event or treatment option and to date there has not been a narrative framework developed that can be used in practice to inform and plan patient care. The provision of person-centred care that is holistic and that takes account of patient's beliefs and values can be enhanced by incorporating narrative approaches in care within a practice development framework. The ensuing chapter will outline and discuss the methodology used to develop and evaluate a methodological framework for a narrative based approach to practice development and person-centred care in residential care settings.

Chapter 5 Action Research

Introduction

The literature review shows that care in long term residential settings for older people is moving away from the biomedical approach and adopting a more person-centred one. The review also illustrates how narrative can help shape the way care is planned and organised. The literature provides a justification for conducting a research study to investigate how narrative approaches impact on care for older adults in residential care settings. To date narrative approaches have focused on either using stories to describe patients experiences or as a method of reminiscence therapy. What has not been researched is utilising stories within a practice development approach to ascertain if this approach would enable nurses to provide care that is person-centred. This chapter will outline the aim and research questions. The research methodology and rationale for the choice of methodology will also be explained and discussed along with an outline of the data collection methods and the approaches undertaken in the analysis of the data collected. It will conclude with the development of the methodological framework, the approach taken in its development and will provide a description of the framework and its operational elements

Research Aim

The aim of the study is to develop and evaluate a methodological framework for a narrative based approach to practice development and person-centred care in residential aged care settings.

Research Questions

1. How does narrative help to achieve a depth of understanding of the life-world of older adults in residential care?
2. To what extent does the implementation of a narrative approach to care enable nurses to operationalise person-centred care?

3. How do nurses make sense of narrative experiences in the assessment, planning, delivery and evaluation of care?

Research Methodology

Introduction

The chosen methodology of this study is action research (AR). This methodology was chosen because it can offer a way of generating knowledge that comes from practice. It is both collective and participatory and seeks to change practice. Action research is different from traditional research methods in that it is less concerned with generalisability and more concerned with the processes of achieving change (Badger 2000). Action research sits well with nursing practice development, as many of its processes can be used to explain practice initiatives and the implementation of changes in practice (Reed 2005).

Action research is focused on problem solving and is more than a single approach. It is in fact made up of several different paradigms. Action research is ideal to enable practitioners to bridge the theory practice gap. Rolfe (1996) believes that action research offers the best chance of facilitating the introduction of research into practice. It identifies a problem and proposes a change which will bring about improvement in practice. Its problem focused approach has the potential to be seen as attractive by nursing managers, however, its collaborative, participative nature along with its bottom up approach may be problematic for some managers (Badger 2000). Research is valued by practitioners when it is seen as having a tangible benefit. Action research is about practitioners reflecting on their practice in order to understand that practice better and sometimes justify how they conduct their practice (Carr & Kemmis 2003). In order for AR to work, the researcher must have a desire to change practice through innovation (Gallagher, Truglio-Londrigan & Levin 2009).

What is Action Research?

The concept of AR was developed in the 1940s in order to contribute to the scientific knowledge about organisational structure (Lewin 1946). Lewin believed that the researcher had to participate in or interact with the system under study in order to understand the system and also to affect change. AR is about finding solutions to

problems that occur in practice. It involves collaboration between the researcher and the practitioners, requires some change to occur in practice and involves all stakeholders (Gallagher, Truglio-Londrigan & Levin, 2009). It is a cyclical process where knowledge gained in a previous stage influences the action in a subsequent stage. It is always flexible, often unpredictable and is focused on the researcher's professional values, as well as, methodological considerations (Badger, 2000). Winter (1998) talks about the researcher finding their "authentic voice", but AR is also about all the participants of an AR project having a voice and that voice being heard. It is also about using that voice to question preconceived ideas and mores and to assert new ideas and ways of doing things. This voice needs to enable practitioners to be empowered where they are constantly challenging 'prescribed assumptions'. At the heart of action research is the development of a learning organisation where mutual learning occurs, in the case of residential care settings, between practitioners and residents. Winter (1998) believes that an educational process is implicit in action research and that there has to be an educational component built into it or what Dewing (2010) calls 'active learning'.

Active learning according to Dewing (2010) is an overarching approach to learning that incorporates several learning methods and that take account of the experiential knowledge of the learners. Active learning traditionally would have been seen as anything that involved learners thinking and reflecting on what they are doing (Young et al. 2010). Dewing (2010) however, believes that within practice development work, active learning involves more than this. It is concerned with ensuring that different "ways of knowing" are privileged, that critical dialogue occurs and that combining these enables learning to occur for all in the workplace where people are encouraged to do things in a different way. This is what Dewing (2010 p.3) refers to as "Moments of Movement". These moments enable the practitioner to develop and the culture to transform. Further, learners who engage in these ways of working become more person-centred in their approach to care and acquire an ability to critically question practice learning activities and how these impact on the practice culture.

Action Research Definitions.

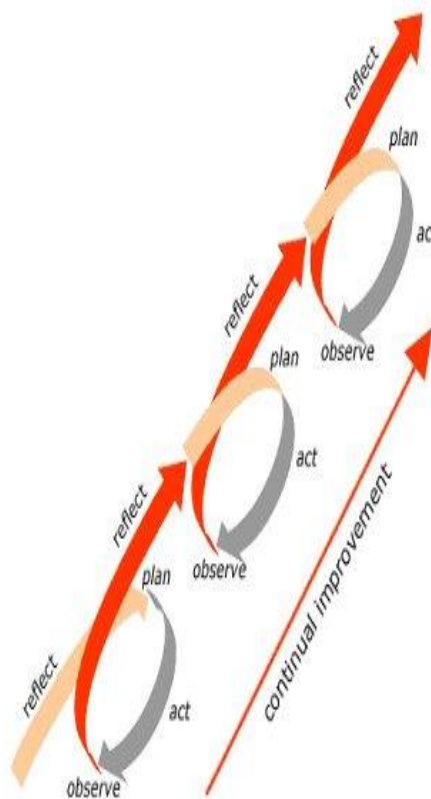
There is no single definition of AR. What separates AR from other practice initiatives is its focus on scientific enquiry (Badger 2000). Interventions or practice

changes are underpinned by theoretical deliberations (O'Brien 2009). Researchers and research participants become co-researchers which makes it easier to implement the change as the participants are invested in seeing the change occur (Badger 2000). It is also set in the real world of practice and as such is valued by participants as an empirical rather than academic initiative (Bellman, Bywood & Dale 2003). Definitions of AR focus on solving problems using cycles of action and reflection.

Lewin's (1946) seminal work on action research focused on social inquiry. He described AR as:

"A spiral of steps, each of which is composed of a circle of planning action and fact finding about the results of the action"

(Lewin 1946 p. 206)



Contemporary definitions have evolved from awareness, empowerment and collaboration (Bowling 1997) to collaboration, inclusion and participation (McCormack et al. 2007). Reason and Bradbury (2008) define AR as:

“A participatory process concerned with developing practical knowing in the pursuit of worthwhile human purposes. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people and more generally the flourishing of individual persons and their communities”.

(Reason & Bradbury 2008 p. 7)

Action research can be used by researchers to achieve patient outcomes, improve work or living conditions and implement new initiatives. It involves not only the researchers but also the people who are directly affected by the research. It provides all parties with a sense of ownership of the project and ultimately all become collaborators in effecting change (Gallagher et al 2009). Taking account of both of these definitions of AR and being mindful of both the context and culture where this research is set and that the aim of the study is to develop the knowledge and skills of the participants, the following working definition of Action research is used in the current study.

“AR is research that is done with and by “insiders” in an organisation that is predicated on an action or cycles of action and that involves critical reflexivity. Each cycle should inform and increase the researcher’s knowledge of the problem under investigation”.

(Titchen & Manley 2006 p.341).

Origins in healthcare.

The origins of AR are positioned at the beginning of the twentieth century (Waterman, Tillen, Dickson & de Koning 2000). Kurt Lewin is widely considered to be the creator of the term AR and was the first to develop a theory of AR that was acceptable to the social sciences. He was influenced by the philosopher John Dewey and drew heavily on progressive educational theories to address problems of social conflict. Dewey focused on addressing conflict and change management using group dynamics and processes to effect change. Lewin developed a cyclical process that focused on planning, action, evaluation and reflection that was set within the context of an organisation and that focused on problem solving. According to Lewin (1946) change happens best if it is implemented by those who have shaped it (Singer et al. 2007). While Lewin is credited with coining the term “Action Research” his colleague Jacob Moreno (1892-1974), with whom he shared students, equally helped to shape the way AR combines theory and practice. Guntz (1996) believes

that Moreno is often neglected in favour of Lewin and that his contribution is equally as important. Moreno, a physician and dramatist, invented sociometry - the science of networks and relationships and how that influences action. He is thought to have been the first to use terms such as interaction and action research and to utilise approaches such as field research and participants as co-researchers to focus on social improvement (Guntz 1996). However Lewin, probably due to being solely referenced in post war German action research developments, has gained ascendance. Nevertheless, it is important not to discount the contribution of Moreno or indeed the influence of relationships and networks in action research approaches and studies. In the present study, the importance of participants as co-researchers and the effect of relationships on the implementation bears out this importance.

Educational action research which developed in the 1970s has had a major influence in the development of AR in healthcare. Researchers such as Stenhouse and Elliott (Noffke 1994) promoted the integration of participatory methods with change in practice. Their methods, however, focused on the individual as a researcher and effector of change and they tended to make light of the role of the group in this process. In contrast, the methods of Carr and Kemmis (2003) seemed to resonate with healthcare professionals and their approach of working with groups to collectively bring about change is one that has been adopted in several healthcare research studies. It is important to note that healthcare AR is different from educational AR and it is perhaps the work of Heron (1996), Reason (1994) and Reason and Bradbury (2008) that have most influenced the type of AR currently being carried out in healthcare settings. Collectively, their emphasis on the holistic approach and participatory inclusiveness while promoting the use of knowledge in action has found favour with healthcare professionals.

Types of Action Research.

Three distinctive types of AR are reported in the literature: technical, practical and emancipatory (Kemmis & McTaggart 2000, Lincoln & Guba 2000, Roberts 2002). These types have similarities to the types of PD outlined earlier: technical and emancipatory. PD's focus on the development of person-centred workplace cultures and the evaluation and utilisation of that knowledge aligns it within the same philosophical and methodological paradigm as AR. Both approaches use methods of learning in and from practice to identify areas where improvement can occur and to implement change. Technical action research is based on defining problems

externally and finding solutions to fix these problems. In this approach, the researcher identifies the problem and the intervention to be used. It does not concern itself with the beliefs of the practitioners and often change only occurs for the length of time the intervention is being implemented (Kemmis 2001). Its purpose is to test a specific intervention for solving a problem and the researcher is seen as an expert who gains the agreement of the group to implement the intervention in the way the researcher wants it done (Boog 2003). Its main concern is to change outcomes and it does not concern itself with informing the decision making abilities of the practitioners. Technical AR can be used in the implementation and subsequent evaluation of practice guidelines, where the guideline is developed by the researcher, given to the staff to implement and evaluated by the researcher (Boog, Preece, Slater & Zeelen 2008).

Alternatively, practical action research collaborates with practitioners on a problem of mutual interest. Practical AR is influenced heavily by the work of Schon (1983, 1987) with its aim to change both the understanding of the practitioner and the way that practice is performed. By contrast, emancipatory action research (EAR) is based on Marxist approaches (Boog 2003) where emancipation has a twofold outcome. EAR improves the competencies and problem solving abilities of the research participants locally at the research site and has the potential to effect other similar situations in the future. It not only enhances the skills of the action researcher and co-researchers, but also increases the AR knowledge base and broadens the theoretical approaches used. EAR can lead to empowerment whereby participants have equal standing with the researcher and where their uniqueness is valued. The knowledge gained through EAR is through a mutual approach between the researcher and participants, where the participants are seen as co-researchers. It involves a hermeneutic process where the co-researchers know one another and are able to realise their potential as critical problem solvers (Reason & Bradbury 2008).

For an AR project to be emancipatory, the intent at the outset must be to realise an emancipatory effect. An effect where not only the knowledge of the practice and practitioner are transformed but also where the practice setting and culture of care are altered positively (Ozanne & Saatcioglu 2008). An EAR project that ensures participants have control over their personal growth and decision making abilities

can lead to empowerment. Being empowered, however, depends on whether the participants in the project wish to be empowered. According to Boog et al. (2008), empowerment is only possible if those taking part in the research allow themselves to be empowered. In the present study, an EAR approach was adopted. The participants had the option to opt out and not take part therefore by assenting to be part of the AR implementation they were also allowing for the possibility of being empowered.

Narrative Inquiry as Action Research

In AR dialogue is fundamentally involved in interpreting both experiences and events (Simmons 2006). Participants and researchers collaborate to develop action cycles. They achieve this through a process of reflective dialogical action, where mutual understanding is reached through critical reflection on their mutual understanding of events (Grant, Nelson & Mitchell 2008). This sharing of personal narratives is what links AR to narrative inquiry and what enhances the inquiry in action. This inquiry can be both informative and challenging. It is these challenges that enable practitioners to identify areas where meaningful change can occur. It also can help to develop better ways of working that can lead to the implementation of change through open and democratic dialogue. Narratives are fundamental to the process of action research. In fact it would be impossible to write or do action research in a non-storied way. Change in AR is not just an abstract concept, it is brought about by thinking and acting on identified and discussed challenges (Cardiff 2012). Both narrative and action research offer the opportunity of seeing anew, looking at old practices and developing new ways of working. The use of narrative in AR enables us to use our own stories to derive meaning from our experiences (Walker 2007). Narrative opens up the vagueness of everyday practice. It also captures the complexity of human action and enables us reflect on the knowledge we already possess (Walker 2007).

According to Habermas (1984), without shared understanding there can be no meaningful communication. Habermas's (1984) theory of communicative action states that people relate to each other through co-operative interpretation of experiences and in the way they understand them. AR is about eliciting that shared understanding of this critical reflectivity. Similar to AR, it encourages a mutual recognition that takes account of the understanding of others. Communicative

space in AR enables participants to make sense of their experiences through discourse. The purpose of inquiry is to achieve concerns amongst human beings about the way we act or are. Similar to Habermas' (1984) 'Theory of Communicative Action', action research should involve ongoing critical dialogue amongst the members involved in the research study (Conle 2001). Narrative inquiry is a method of inquiry, as well as, a method of social personal and professional development. Narrative can be used as a way of illustrating data and as a way of creating co-constructed interpretation of actions and events (Columbo 2003). This is usually done in a collaborative way. Communicative action does not recognise power relationships and aims for a mutual understanding by enabling ways of being with one another that see all participants as equal. Similarly both AR and narrative enable people through the use of language to both define and interpret situations. Individuals are connected by their mutual desire to reach understanding of the boundary between systems and life world (Habermas 1984). In AR and narrative inquiry the purpose of inquiry is to achieve thoughtfulness amongst human beings about what we do (Conle 2001). For this reason, while AR was the methodology used in this study the overarching approach is one of narrative inquiry, with narrative approaches and methods used in the development of the framework, its implementation in practice and the evaluation of both the implementation and overall evaluation of the study.

Context of the Study

AR is about working in communities. These communities have a shared interest in exploring the topic under investigation, developing new knowledge that will in turn change the way things are done and improve quality of life and quality of the work experience (Singer et al. 2007). A fundamental element of EAR is that it first starts out with a problem that is relevant and of interest to the group of people who are going to be participants in the AR project. It assumes that all stakeholders – that is everyone who is affected by the research – should be involved in the process (Boog 2003). In this way, co-researchers build a communal understanding of the problem under investigation and develop shared visions for solutions to the problem (Badger 2000).

The Setting

This AR study was conducted in a residential care setting for older adults, where I worked as a practice development facilitator. The residential care centre has five long-term residential care units. Each unit has an average of 20 residents aged 65 years plus. There is an open visiting policy in existence and families/friends are encouraged to visit residents whenever they want. Family/friends are also encouraged to become involved, with the residents permission, in planning care and activities in conjunction with the staff. Each unit comprises a senior nurse manager (CNM2), a junior nurse manager (CNM1), 13 nurses (both full and part-time) and 5 health care attendants (HCAs) providing 24 hour care and assistance to residents. Medical cover is provided, under the direction of a Consultant Geriatrician, by a Senior House Officer who visits the unit routinely. An Activities Coordinator provides a scheduled programme of activities for all residents. The site is very disparate with most of the units not having any relationship geographically to one another.

The study was conducted in two wards. Due to ongoing reconfiguration at the time of the study and uncertainty about closure of the other sites it was deemed appropriate to involve only the two wards. The unit where the study was conducted consists of two wards (37 beds in total) that were situated in the same building; one 19 bed ward occupying the downstairs, known as Unit 1 throughout the study, and the other ward with 18 beds upstairs, Unit 2. In addition residents received support from physiotherapy, speech and language therapy and dietary services. The staff were supported by a management team led by a Director of Nursing and educational support was provided by a Practice Development team. Both staff and residents had access to a Care of the Older Adult Advanced Nurse Practitioner who supported the management of complex conditions.

Negotiation of Access.

Permission to carry out the study and access to the hospital was sought (Appendix 2) and granted (Appendix 3) from the Director of Nursing. The Clinical Nurse Managers on the specific wards where the study took place, were asked for and granted their assistance in recruiting the population sample and for access to the ward. A total of eight residents participated in a focus group and all 37 residents were involved in the ongoing action research approaches that occurred throughout this study.

Participants

AR has a goal of common unity of all participants (Singer et al. 2007). The participants in this study were all the staff (N=38) and residents (N=37) who worked and resided in the unit at the time of the study. These participants took on the role of insider researchers. My position in the facility meant that while I interacted with the unit for several of their learning initiatives I was not based on the unit and as such had minimal interaction with the residents who lived there. This prior knowledge of the people and the setting allowed me to have an both an insider and outsider perspective on the study. An insider outsider perspective according to Hellowell (2006) allows the researcher have empathy with the participants and also to maintain an objective distance from the research. AR seeks to make sense of the problem identified in the way it is experienced by the co-researchers and stakeholders (Reason & Bradbury 2008). The researcher in AR is not seen as an expert who is involved in doing the research, but as an adviser who can be relied on to enable the research to take place and who can facilitate the participants in working towards a solution to the identified problem (Roberts & Dick 2003). The skill of the facilitator determines how the participants interact with the research. A skilled facilitator will enable participants to become fully engaged in the process and to ultimately choose their own path, which is true emancipation (Lincoln & Guba 2000). While having an emancipatory intent and theoretical basis is no guarantee of success, proceeding without this could result in a study that at best will not realise any emancipatory effect and at worse could dis-empower the research subjects This approach according to Kemmis and McTaggart (2000) allows people to own the research and use it to describe their own situation. It is true that some researchers may not be equipped to enable practitioners to reach this stage. It is also likely that practitioners themselves may not be able to work in a collaborative way (Roberts & Dick 2003). Ethical considerations and access negotiation will be dealt with later in this chapter.

A population can be defined as the total number of units from which data can potentially be collected (Parahoo 2006). In accordance with the purpose of this study the target population was all individuals who worked and resided in the residential care setting. On Unit 1 and Unit 2 Nurses and care assistants both healthcare attendants (HCAs) were responsible for the day to day care and daily activities of the residents, Multitask attendants (MTAs) were responsible for cleaning

and kitchen duties. All staff working on both units (n=38) were invited to take part in the study. 100% (n=38) of staff agreed to participate.

This included:

Participating in focus groups

Participating in facilitated work-based learning groups

Conducting interviews with older people and with relatives and friends.

Conducting and being participants in observations of care.

Implementing the Framework of Narrative Practice.

In addition the CNMs were invited to be co-facilitators of the work-based learning groups. However due to the attrition of staff this became an ongoing process with new staff recruited into the project as they joined the work force.

Inclusion Criteria

Staff

CNMs (n=4), nurses (n=20) and support staff (HCA, MTA) (n=14) employed in the participating site at the times of data collection were included in the study. Differing configurations and numbers of staff took part in work-based learning groups and these numbers will be outlined in the section discussing these activities.

Residents including those with dementia

A resident for the purposes of this study was defined as an older adult (> 65 years of age) who lived in the residential care facility.

- Resident in participating units at the time of data collection
- Be English speaking
- Able to give written verbal or process consent to participate
- Be willing to partake in a focus group lasting approximately 30 mins-1 hour

Exclusion Criteria

Residents

Any resident who did not meet the above criteria.

Any resident who fitted the criteria but who, due to ill health, was unable to participate in the study

Action Research Ethical Principles and Application to this Study

Ethics and ethical considerations in AR have mostly been addressed from the perspective of ethics review committees. There is very little literature available on how researchers address ethical issues that can sometime arise in the conduct of an action research study. These issues often include risk/benefit of implementation/non-implementation, empowerment/disempowerment and sometimes issues of social justice. Disagreements between stakeholders and competing agendas can lead to a disconnect between espoused desires to change practice and a rejection of identified actions to implement change (Boog et al 2008). This can lead to a break down in team communication and the risk of creating a workplace of discontent. The benefit of implementation of AR is that participants gain research knowledge and skills. These new skills can be utilized to continue to identify the organisational culture and lead to the identification of improvements and change (Jagosh et al. 2012). Benefits are not only related to the personal and professional growth of the participants but also can be transferrable to the research site. Issues of social justice in AR, referred to in the literature, are related to the processes that take place when implementing AR. Processes are focused around ensuring that interventions are appropriate and decisions are authentic, taking account of all the stakeholders and not just a few (Bristol & Ponte 2013).

Ethical approval for this research study was granted by the Clinical Research Ethics Committee of the Cork Teaching Hospitals (Appendix 4) and by the University of Ulster Research Ethics Committees (Appendix 5). Both residents with and without a cognitive impairment were included in the study. Residents with full cognitive ability took part in focus groups and the views of residents with diminished ability were elicited through their agreement with changes or assent to activities that took place as part of the AR approach. This approach was similar to the way staff engaged with residents with dementia in their daily care episodes and did not pose a challenge. Despite the recent popularity of person centred methods of care (McCormack & McCance 2006, Keedy et al. 2005, Nolan et al 2004) there still remains a paternalistic view of people with dementia. Obtaining informed consent from participants in research is a process that protects their welfare and rights (Dooley & McCarthy 2005) and is the universal principal applied to participation in research or in agreeing to treatment. It is based on the principles of nonmaleficence, beneficence, autonomy and justice and includes five basic human

rights. These are the right to self-determination, right to privacy and dignity, right to anonymity and confidentiality, right to fair treatment and right to protection from discomfort and harm (Dooley & McCarthy 2005). The principal of informed consent is that the person giving the consent has the ability to understand the process and the ability to judiciously decide to participate (Woods & Pratt 2005). Dewing (2002) believes that this traditional view of consent may be exclusionary for persons with dementia and advocates obtaining consent for persons with dementia by employing methods that are rooted in relationships and promote personhood as a moral right based on recognising the “embodied self”. Dewing (2002) proposes a method of consent called process consent where permission is obtained from the residents relative to approach the resident and actual consent is obtained from the resident either verbally or by observation of cues that normally signify consent for the resident. This method recognises that the values and beliefs of the person with dementia are equal to the person who is not cognitively impaired (Nagel 1970, Singer 1993, Dewing 2002).

In this research study, eight residents were drawn from an existing residents forum group. This group comprised residents who had varying levels of cognitive awareness. Residents were approached by the Clinical Nurse Manager on each ward and invited to take part in focus groups. Relatives of residents who had cognitive impairment were also approached by the manager and invited to give consent for the researcher to approach the resident. An information leaflet (Appendix 6) was provided to selected residents and signed informed consent (Appendix 7) verbal consent or assent was sought from all residents who were unable to give written consent by the researcher prior to commencing the research, and ongoing throughout the study by the staff when undertaking AR processes. In this study all of the residents who took part in the focus group gave either verbal consent or assented to take part. They did not wish to sign the consent form, reasons given for this were they were happy to take part without signing, their eyesight wasn't good, and they had not signed anything in years so did not feel the need to do so now. This adhered to the principles of respect and self-determination (Lo-Biondo-Wood & Harber 2014). An invitation to partake (Appendix 8) and an information leaflet (Appendix 9) regarding the study was sent to all staff working on the unit. All staff who agreed to partake were asked to sign a consent form (Appendix 7). All focus group interview transcripts were numbered and participants'

anonymity was protected. Focus group interview tapes and transcribed interviews were kept in a locked drawer that could only be accessed by the researcher.

Data Collection Methods

Data were collected using a variety of methods throughout the lifetime of the study. A two phase approach was undertaken with data generated in Phase 1 informing the development and generation of subsequent data in Phase 2. The approaches undertaken, data collected, the purpose of the analysis and the method of analysis are outlined in Table 1. Phase 1 comprised secondary analysis of existing interviews (N=46), that had been collected as part of an national research study, National Person-centred care Practice Development Programme (McCormack et al 2010). These interviews were analysed by me, Clinical Nurse Managers (CNM)(N=12), in focus groups and by two experts. The processes utilised in this analysis will be dealt with in greater detail in the section on narrative analysis. The information gained from the analysis influenced the development of the methodological framework, the Framework of Narrative Practice (FNP). This framework was implemented in practice and the ongoing workplace learning activities during the implementation led to three action cycles: (1) identification of culture, (2) development of action plans and (3) implementation of action plans. Each of these action cycles generated further data that was used in both the ongoing evaluation and overarching evaluation (Chapters 7 & 8). These methods are outlined in Table 1 and will be explained in more detail in subsequent sections on narrative analysis, development of the framework and the three action cycles that occurred in the implementation of the framework (Chapter 5 & 7) .

Creative Research Methods

The use of creative methods in evaluation evokes different ways of knowing ones that enable us to see and understand things in a different way. Being free from the constraints of categories and codes and instead using an image to evoke understanding enables the person's imagination to reveal insights that often cannot be articulated in words alone (Simons & McCormack 2007). According to Selby, Shaw and Houtz (2005) there is a lot of overlap between creativity and problem-solving. Taking a creative approach helps us to delve deeper into the problem under consideration (Sullivan 2009). It allows us to not only answer questions but to see and comprehend issues with new insight and to develop new ways of knowing. This

overlap fits well within a practice development/action research approach where the purpose of the study is cooperative inquiry. Narrative as the overarching paradigm of this study and the study's focus on story creatively brings together different elements of the research project in new ways. These ways offer us new ways of working, new ways of understanding and new ways of knowing. The creative methods used within the study will be explicated as they arise however, creativity was used extensively in the analysis and evaluation of the study and this will be briefly outlined below as well as in the upcoming chapters dealing with analysis and evaluation (Chapter 7 & 8).

There are several different creative data analysis methods used throughout the study. These are outlined in Table 1 below. Secondary data analysis is outlined in greater detail on p. 91. Thematic analysis and documentary analysis are discussed in Chapter 7 & 8. Creative hermeneutic data analysis is used in both the development of the Framework of Narrative Practice and in the ongoing and overarching evaluation of the project. Due to the extensive role creative hermeneutic data analysis takes in this study an outline of its approach will be presented here along with a more in-depth explanation of its role in each phase of the study as it occurs. This approach facilitates the creation of a mental image of the data which in turn facilitates the creation of themes related to the data collected. The approach taken is outlined below:

Creative Hermeneutic Data Analysis (McCormack, &Boomer 2010)

1. Read the data and form general impressions, observations, thoughts and feelings. (Make some notes on these if it helps and will also be useful to check back on later).
2. Create an image of your impressions etc → captures the essence of the data. (What did you see, feel and hear in the data).
3. With another group member 'tell the story' of your creative work, while your colleague writes the story verbatim.
4. Using the creative image as the centre piece, and the story (written) and other notes you may have made @ Step 1, theme the image:
 - as many themes as you like
 - Write one theme on each post-it and stick on the creative image.
5. Group to discuss the individual themes and devise 'shared themes' (categories). Must have the whole group agreement on these.
6. Use categories and themes to create story of the data i.e. write a metanarrative. (all participants contribute to this).

This approach brings together hermeneutics, facilitation and creativity and enables the analysis of multiple data sets.

Table 1 Overview of Data Collection and Analysis Methods

	DATA	PURPOSE	ANALYSIS
PHASE 1 Development of a Framework of Narrative Practice			
Narrative Analysis of Existing Interviews	Narrative research existing resident narratives (N=46)	Development of narrative framework	Secondary data analysis Using a 2 stage approach -common elements of narrative -mapped on to person-centred nursing framework taking schematic organisation of storymap (Richmond 2002) and life story schema (Bluck & Habermas 2000), into consideration.
Development of the Methodological Framework (FNP)	Focus groups and workshops		Adaptation of Creative hermeneutic data analysis (Boomer & McCormack 2010) and Hsu and McCormack 2010) questions for group discussion
PHASE 2 Implementation of the Framework in Practice.			
Framework Implementation and Evaluation	<p>Work based learning groups (WBL) Nurses, healthcare assistants and carers.</p> <p>Identification of Culture</p> <p>Observations of care</p> <p>Resident interviews</p> <p>Resident Care Plans</p> <p>All meeting notes, and data collected throughout the programme. Researchers field diary and reflections of practice</p>	<p>Implementation and ongoing evaluation of practice development initiative.</p> <p>Overall evaluation of the project</p>	<p>Thematic analysis by WBL groups on programme days -observations of care -Interviews -Identification of culture from WBL groups</p> <p>Documentary analysis -Nursing notes. Using documentary analysis tool -Creative Hermeneutic data analysis (Boomer & McCormack 2010) All notes from meetings, researchers field diary, reflective</p>

Phase 1 Development of a Framework of Narrative Practice

Narrative Analysis of Existing Interviews

The findings of this research study will be outlined under the phases in which they occurred and the processes that were undertaken in each of these stages. Phase 1 findings will be presented under narrative analysis of existing resident interviews and development of a methodological framework headings. In Phase 2, findings will be presented under the implementation of the framework in practice.

Narrative analysis of existing interviews was concerned with secondary data analysis of interviews (see samples Appendix 10) (N=46) collected as part of the National Practice Development Person-centred Care Programme outlined in Chapter 1. These interviews were conducted with older adults in residential care settings, on 3 sites, in the Republic of Ireland with the aim of finding out what the lived experience for older people in residential care settings was like. Both an internal and external facilitator undertook the interviews on the 3 sites. An existing framework of narrative practice was not available to be implemented and tested in practice therefore, one needed to be developed. The interviews from the national programme contained a rich data source and its aims were congruent with the aims of the present study. Thus it seemed unnecessary to collect new interviews. The interviews were utilised in the development of the new framework that could then be implemented in practice using an AR approach. Permission to reanalyze these interviews was sought from and granted by the three sites where they were collected (Sample of letters Appendix 11). Findings from previous research has shown that secondary data analysis can provide a more insightful interpretation of the primary data and may also aid in research design (Church 2002). These interviews were analysed independently by me, by CNMs (n=12) in focus groups and by two experts. The processes undertaken will be outlined in more detail in the next section.

Secondary Data Analysis

Secondary data can be utilised to answer new research questions or indeed to challenge the original research findings. This data usage ensures that the best possible use of the data is achieved and it can lead to further understanding of the results obtained in the first study (Coyer & Gallo 2005). A major disadvantage of secondary analysis is that the data were collected for another purpose and this could impact on its usefulness (Smith 2008). Coyer & Gallo (2005) believe that an original data set can be used to further develop a concept that has emerged in the original data or to validate the original results. In this study, secondary analysis was conducted in order to further analyse the life world of older adults in long-term residential care.

The analysis of the interviews that I conducted in Phase 1 of this study was influenced by the theoretical works of Labov (1982), Ricour (1985), Mischler (1991), Polkinghorne (1988), Bluck and Habermas (2000) and Riessman (1993) as described in Chapter 2. The search for a universal plot led me to consider the temporal experiences of past, present and future. The analysis is based in part on Richmond's storymap (2002) and on Bluck and Habermas' (2000) schema (Figure 2). Richmond's storymap is influenced by the theories of Brunner (1987,1990,1994), Mischler (1991) and Connelly and Clandinin (1990, 2000). These theories are explained in more detail in Chapters 2 and 4. The analysis relies on analysing stories through three dimensions, temporal, personal and experiential. In this study, temporal refers to the past, present and future, personal refers to how organised or disorganised the story was and experiential refers to themes, characters, and settings evident in the story (Richmond 2002).

The analysis took account of the hermeneutic relationship between life and story and was influenced by the story map (Richmond 2002) and the life story schema (Bluck & Habermas 2000). A schema is an "active organisation of past reactions and past experiences" (Bartlett 1932 as cited in Bluck & Habermas 2000 p.5). Schemata are a "mental organisation of one's past that models one's experience with life" (Bluck & Habermas 2000 p.5); they are the mental representation of a person's life. Bluck and Habermas' (2000) theoretical model of schema is based on four tenets of coherence. These tenets are temporal, causal (structured events), thematic (life themes) and biographical (cultural ideation). Coherence binds the

current self with the past self and links events that occur over time. A life story schema helps to maintain 'continuity' of life story by placing order on events and helping to connect significant events from the past with life in the present. Schema theory is based on the mental structures that enable humans organise and make sense of information (Bluck & Habermas 2000)(Figure 2).

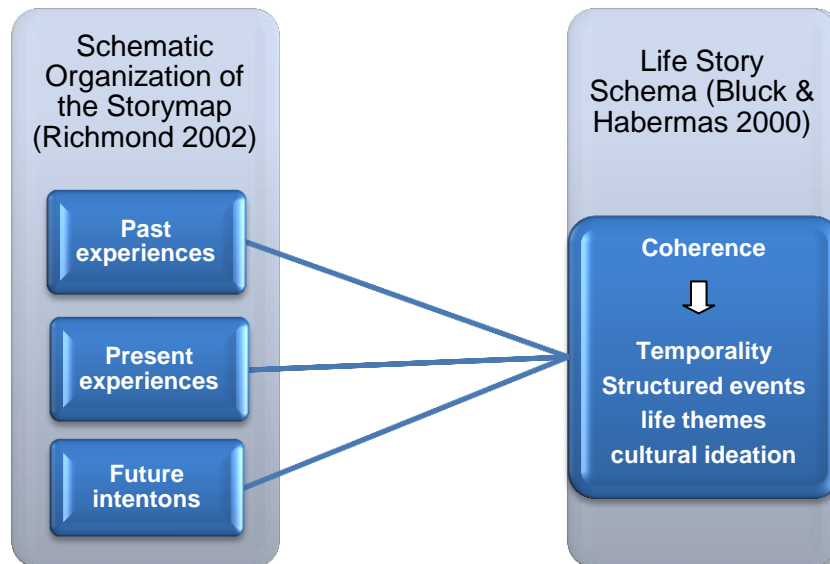


Figure 2 Relationship of Schematic Organisation of Storymap to Life Story Schema.

Three copies of the data were made, One used as a master copy of the original interviews in the format they were collected, this could be referred to for clarification if needed throughout the analysis to ensure that key elements from interview were not missed. The second, complete copy of the reconceptualised interviews, as outlined below, was used throughout the analysis as a reference and the third, a copy used for coding, on this copy passages were highlighted and extrapolated as outlined in the section on coding below. Transcripts were read through twice to provide an essence of the interviews and gain familiarity with the language used in the interviews. Interviews were then read to identify if they adhered to the storymap i.e. had a beginning, middle and end and also to ascertain that they adhered to elements of the life story schema (temporality, structured events, life themes, and cultural ideation). Interviews that did not adhere to any of these elements were rejected. A total of 46 interviews were read with 6 being excluded for not meeting the criteria for analysis (See Appendix 10 for examples of interviews).

Interviews were reconceptualised to fit logically into the past, present, future or beginning, middle, end elements of the story map by colour coding passages of the interviews that fitted into these elements. Interviews were then restructured to flow logically from beginning to end by cutting and pasting the coded passages. This is what Bluck and Habermas (2000 p.123) referred to as 'linking elements of life with each other and with the present self' and is, according to Lai (2010), important if researchers are to fully understand both the tacit and explicit information in a narrative. Because I wished to make a distinction between themes that emerged in passages that were designated past present and future, all data that referred to a particular time period were extrapolated and pasted into a word document. Therefore, the data from all the interviews that related to past was in one word document; likewise with present and future. Clandinin (2007) believes there is no correct method of analysis, but the approach taken should suit the purpose of discussion. Therefore, it was considered appropriate to reorganise the interviews so that they could be clearly understood (Riessman 1993, 2000, Clandinin 2007, Hsu & McCormack 2010). Each data passage retained its resident code designation to help identify the original interview the data came from. These transcripts were read through several times and text that appeared to describe important or repetitive comments was highlighted (Hosburgh 2003). These highlighted passages were given codes. This is known as open coding and what Graneheim & Lundmann (2004) describe as ascribing a meaning unit to the text. These codes represented the words of the respondents and were freely generated. The codes were further reduced and focused into categories keeping codes with similar content together. This was done by cutting and pasting the codes into a word document.

Creating categories according to Coffey & Atkinson (1996) is a central feature of qualitative research; these categories must share a common thread or theme. Categories were further analysed by working with each category and referring back to the original transcripts. A total of 17 categories emerged with 6 being ascribed to the past, 7 to the present and 4 to the future (Table 2). This breakdown of themes proved useful as it helped to identify areas or aspects of life story that residents associated with the past life and also those themes they associated with their hopes and their aspirations for the future. The categories also provided a deeper understanding of both life and story. There was some overlap between past, present and future where themes used to describe certain aspects of past life

experience were also referred to the same aspect of life in both present and future, therefore some themes were grouped together and a combined set of 12 themes was developed (see Table 4). Because these themes formed the basis of the development of the methodological framework and were such an integral and substantive part of the data for this study the narrative exemplars, subcategories and categories are presented within the thesis in Table 2 to provide the reader with a picture of the relationships between the identified categories and the excerpts from the interviews they related to.

Table 2 Themes from Secondary Data Analysis

Themes relating to Past		
Narrative Exemplar	Subcategories	Category
When I was at home I might just fry an egg for my tea. Just one fried egg. (R29)	Home comforts	Lifestyle
Enjoyed going on holidays with family. (R11) ...travelled up to Croke Park and also here in Killarney and Tralee. I used to go on bicycle – bicycles were not so good that time, wearing out, punctures, chains falling off... (R13)	Travel	
I loved school I was good at school and I liked doing my homework Now I feel useless. (R3)	Importance of education	
At home I used to have plenty of friends calling and plenty of cups of tea or maybe something stronger. (R18)	Camaraderie	
I had a dog called Shep who I miss very much. (R18)	Importance of Pets	
was working as a carpenter by trade – good trade was harder – a lot of hard work – enjoyed my work – was a happy time – everyone was the same. (R13)	Importance of work/past occupation	Life's work
When I was working I used always have plenty of money – money was scarce then but I worked hard for it.. (R21)	Status/Hard work	
I was away for years in London for years childminding, in Aer Lingus, at St. Johns Wood Hospital – nurses aide – was lovely work – was hard. (R4)	Life's work	
I would have liked to marry and missed not having a family. (R 3).	Unfulfilled dreams	Hard Times
My mother had it tough my father died at a very young age... My mother had a tough time trying to rear and educate us...(R 28)	Making do with little or nothing	
I became a widow...my husband was only 39...had no kids so had a lonely life. (R4)	Loneliness	
	Tough times	

I worked hard for no money, It wasn't there. (R31)		
<p>loved baking, used to make my own bread, lovely homemade brown bread and currant cake and cooked bacon and cabbage – my husband's favourite dinner. (R5)</p> <p>Used to travel to football matches in the evenings – it was very entertaining kicking the ball – I played, not too much (R13)</p> <p>I used to walk all over Cork. Some nights I used meet my friends down in the local for a few drinks (R24)</p>	<p>Past activities/hobbies</p> <p>Sport</p> <p>Socialising</p>	Past Interests
<p>I always kept very well dressed wore a tie every day – try not to go out without being well dressed- (R13)</p> <p>Had own house... the ruffians broke in there and they made trash of it. Not fit to live in after... (R 14)</p> <p>Had several farms one in Fermoy, one in Ballyporeen 3,500 sheep in Fermoy...I was a great judge of sheep... Had one horse, he was a cob... sub-contractor for P& T I had nearly a hundred men working that time. (R21)</p>	<p>Maintaining Standards</p> <p>Respect</p> <p>Standing in the community/place in society</p>	Status
<p>I was falling and they'd find me on the ground and that's when it was decided I couldn't stay in the house. It was very hard for me. (R24)</p> <p>The hardest thing is sitting down, we're not used to sitting down. Women were always on the go. (R9)</p> <p>then I fell and split my leg and all across the back... and then the next thing is I landed here and I didn't know what this place was either and I was sitting below with the other patients and I was just looking at them all.R2</p>	<p>Realisation of inability to self care</p> <p>Change in lifestyle</p> <p>Unplanned admission</p>	Failing Health

Themes relating to Present

Narrative Exemplars	Subcategories	Categories
<p>"I would like the talking to stop at night. They talk up to 11 'Clock at night. (R3)</p> <p>At breakfast when staff are supposed to be feeding patients they're not concentrating ...just talking to each other and they forget about the patient. (R6)</p> <p>One on night duty comes in chewing and I can't understand her diction...she shoves me over...she is rough with the patients. (R6)</p> <p>Some people are treated very badly...If a new patient comes in at meal times a beaker is put in their hand and they are told drink. (R7)</p>	<p>Noisiness</p> <p>Staff attitudes</p> <p>Rough treatment</p> <p>Watching how others are treated</p>	Staff Attitudes

<p>Will have to sign a book to say you are are going out...all wrong. (R14)</p> <p>According to the book I have to wait for someone to come in to take you out. (R20)</p> <p>The day I came in, I was very lucky cause the first person introduced herself as the assistant ward sister,....brought tea and toast... introduced me to my own space and the locker where my things would go.... made me feel welcome and not miserable. (R5)</p>	<p>Dignity, Respect</p> <p>Privacy</p> <p>Importance of introduction to ward.</p>	
<p>I sometimes get depressed in here when I am feeling down. I ding the day long. (R 18)</p> <p>They told me I wouldn't walk again...that closed me down. And I have no hope left. (R7)</p> <p>My sleep is always broken waking during night to go to toilet. This is very tiring and I feel "sick of it all."(R9)</p> <p>Came in 11 years ago and one thing, the patient that you got to know passed away – that was sad... I missed them very much. Before they died they kept up the spirit and I helped them and they helped me. (R13)</p>	<p>Feeling down/ Depressed</p> <p>Feelings of hopelessness</p> <p>Fed up with lot in life.</p> <p>Loneliness</p>	<p>Hopeless/ Helplessness</p>
<p>We would like to stay up later but ... some of the girls work until 6. There would be no one to put us to bed you see. I would love to go out everyday...There would be nobody to take you out – the girls are busy doing work. (R 4)</p> <p>I wash myself they get all the accoutrements around ...and they get my clothes and they just pull a screen around and I wash myself then from the table in front of me and dress myself. And then they come and they bring my wheelchair... while I'm combing my hair and doing my face they bring me out then to the dayroom. (R 29)</p>	<p>Not wanting to impose/be a burden</p> <p>Dependence/Loss of independence</p>	<p>Dependence/ Independence</p>
<p>I look forward to visits from my sisters and friends I like to hear news from the town, how everyone is doing (R1).</p> <p>I am very interested in people I love to hear about events, holidays and families. I live people's lives. (R 9)</p> <p>I am here about 2 years and very happy. I enjoy the company (R 10)</p> <p>I like it in this room (6 bedded ward), I feel people talk more in this room. (R 11)</p> <p>I like the free and easy attitude of staff, they do not try to control the</p>	<p>Importance of maintaining contact with outside world.</p> <p>Living life vicariously</p> <p>Importance of company.</p> <p>Need for interaction</p> <p>Importance of good relationships with staff.</p>	<p>Connectedness</p>

<p>patients . (R 11)</p> <p>I get on better with staff than with patients, patients are deaf, can't communicate. I am younger than the rest - the youngest here. (R20)</p> <p>The men in the ward are very quiet, they don't say much, not much company but a good few neighbours call in to see me. (R 23)</p> <p>My religion is important to me and people take that into account. (R 31)</p>	<p>Lack of/or limited connection with other residents</p> <p>Common interests</p> <p>Importance of religion</p>	
<p>We like to read sometimes the paper, a book – something to kill the time because the time seems long here you know. Old magazines. The daily paper when we get it. (R4)</p> <p>I'm happy with what I have. They ask you what I have. They ask you what you want. (R 5)</p> <p>I ring the bell and then I have to wait for someone to take me to the bathroom and if they are not quick enough I wet the pad. I hate that because I don't want to be incontinent. (R 9)</p> <p>I feel inept all my life I have been a perfectionist. I was always punctual and efficient. Little things make me intolerant. I constantly compare how I would do it myself. I feel I need to relax more. (R12)</p> <p>According to the book I have to wait for someone to come in to take you out ...tis awkward at times ...I don't think they would let me sign out myself. (R 14)</p> <p>Get up around 10 and put to bed at 5 or quarter past. All night in bed twisting and turning. Difficulty in sleeping. 5 is too early to go to bed. Used to go to bed between 11 and 12 Not my taste at all to go to bed at 5. I don't like to disappoint the nurses some are going off at 6. (R26).</p>	<p>Need to keep occupied/fill the time</p> <p>Choice</p> <p>Lack of control</p> <p>Unable to maintain previous standards</p> <p>Lack of self determination</p> <p>Impact of staffing levels</p>	<p>Maintaining Control</p>
<p>there is not enough nurses to do the work. (R30)</p> <p>I've no bell here I have to keep calling, it is very distressing because I am far away from the nurses and I don't know if they can hear me calling. (R7)</p> <p>I feel very apprehensive about the future. (R9)</p>	<p>Staffing levels</p> <p>Feeling unsafe</p> <p>Apprehension for the future</p>	<p>Fear</p>
<p>It could be terminal here, problem of passing the time. I got the books and passed the time with them. I find it hard in the late evening. Spirits tend to go down in the evening. (R 11)</p> <p>We do art on Monday, exercises on Tuesday, bingo on Wednesday and mass on Fridays and Sundays. We</p>	<p>Lack of activity/boredom</p> <p>Importance of activities/being occupied</p>	<p>Being Occupied</p>

<p>don't have to go to everything if we don't want to. And we can relax on Thursdays and Saturdays, even if we want a day in bed. (R 10)</p> <p>I read late at night mysteries – till 12 or 12.30. They let me and they put screens around me so no one is put out. (R 24).</p> <p>I can get out and go to Mass....to a lovely little church...anytime I get the chance. It's a bit of a break in the monotony of it. (R 16)</p>	<p>Continuation of previous activities/hobbies</p> <p>Importance of outings</p>	
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Themes relating to Future

Narrative Exemplars	Subcategories	Category
<p>I feel very apprehensive about the future. (R3)</p> <p>Can't see any light at the end of the tunnel.(R7)</p> <p>When am I going to get better? Whats going to happen to me? (R8)</p> <p>I'm here til I go into a box. (R12)</p> <p>Everyone should give in to something. (R14)</p> <p>The next step for me is down with my parents (<i>being buried</i>) in Ballyanders, Co. Limerick. (R16)</p>	<p>What does the future hold?</p> <p>Hopelessness</p> <p>Fear for the future</p> <p>Futility</p> <p>No future</p>	Resignation
<p>...do you know what I'd like – a burger but they don't do that here – beef burger or fish burger and onions but you can't expect too much. (R5)</p> <p>Don't ask anymore can I be left out. All I hear is no so I'll just wait and see what's happening. (R25)</p> <p>I have accepted my illness at long last. (R30)</p>	<p>Longing to change current status</p> <p>Acceptance</p>	Unfulfilled longing
<p>I feel there should be more privacy for family visits and family staying over night e.g. when patients are ill or dying. (R30)</p> <p>I would of course like to go out but no opportunity to go. (R26)</p> <p>I'd go to another hospital because the irritation and those things don't occur. I don't know what could be done to make it less boring but I'd like to go to St. Patricks. Because of the easier way of it I was there for a month before. It's more calm. I liked it there. (R22)</p> <p>I don't like being in room on my own but try to make best of it.I would like ...(company) (R21)</p>	<p>Lack of facilities</p> <p>No access to outside</p> <p>Privacy and dignity</p> <p>Company, socialisation</p>	Importance of activities
<p>I hope to have better fortune in the future. Your health is your wealth.(R18)</p>	<p>Importance of being healthy</p>	

My aim is to get my hands stronger, hands not as heavy, get my back strong and stand again. My hope will come true. (R20)	Maintaining independence	Health
I'm looking forward to keep going, keep happy with whatever is going on. (R13)	Fitness	

Clinical Nurse Managers (CNMs)(n=12) also analysed these reconceptualised interviews through focus group discussions that I facilitated. A focus group is a special type of group interview where the focus is on interpreting the interaction between the group participants (Webb & Kevern 2001). In this study, focus groups were used as part of the interpretative hermeneutic approach underpinning the study. Action research is about inclusion and participation, and the hermeneutic circle ensures that both the researcher and focus group participants arrive at an understanding together. The hermeneutic circle means that we understood the whole of the story by the interpretations we made of different parts of the story. A total of four focus groups were convened with the CNMs over the course of the study. The purpose of the focus group, at this point of the study, was to arrive at a set of common themes that resonated with the CNMs using Questions for Focus groups (Appendix 12 questions 1-6). A focus group was also held to arrive at an agreed set of themes and took into account the analysis conducted by myself and the two experts. Two further focus group meetings worked on mapping the analysis, also using Questions for Focus Groups (Appendix 12, questions 7-10), onto the PCN framework and developing the Framework of Narrative Practice (Figure 3 & 4). According to Bradbury-Jones, Sambrook and Irvine (2008) focus groups allow for a richer interpretation of the data by allowing the group to hear and gain insight from what is said by other members of the group. However, they also caution that it is very important that each individual member's voice is heard. While Bradbury-Jones et al. (2008) believe that it is down to the skill of the researcher to ensure this happens, I think it is also down to the approach taken with the focus group both in the analysis of data and the way in which that analysis is fed back to the group

The approach taken in these focus groups involved using Questions for Focus Groups (Appendix 12). These questions are an adaptation of both creative hermeneutic data analysis (Boomer & McCormack 2010)(Appendix 12, questions 1-6) and questions for focus groups (Hsu & McCormack 2010) (Appendix 12, Questions 7-10). In this study, using questions 1-6, the CNMs read the interviews

and identified what they heard and how the story made them feel. They were then asked to make a creative expression of the part of the story that most resonated with them. Using what they heard and felt, and the creative expression of the identified part of the story that resonated with them, the CNMs were then asked to outline common themes in the stories. A total of 46 subthemes were identified. The group further discussed these themes and devised a set of shared themes that acknowledged the relationship between the different identified subthemes. A total of 10 themes were identified (Table 3).

The process of arriving at these shared themes is what Mischler (1991) described as 'contextually grounded' conversations where the interpretation is mutually agreed. It ensured that all participants had an opportunity to participate equally in a way that privileged the story of each participant and ensured their voice was acknowledged in the resulting analysis. An argument against focus groups is that they do not provide an in depth insight into what each person's perspective is as they do not offer as much insight as a one to one interview (Webb & Kevern 2001) However, the value of focus groups is that they open a space for discussion to take place where debate can occur and a greater understanding of issues can be reached (Bradbury- Jones, et al. 2009).

Table 3 Subthemes and Themes from Analysis by CNM Group

Identified subthemes	Shared Themes
Not sure who is who What do I want Conflicting desires Hospital or hotel	Resident Expectations
Mixed emotions Happy Anything I want I get I've got company Good memories Contentment I'm lucky	Contentment/satisfaction
Grieving Loneliness Loss	Loneliness
Reminiscence Unrealistic expectations Failure by staff and residents to discuss the fundamental issues Interaction with staff good and bad	Communication (Staff & residents) Inadequate care /lack of holistic, emotional care.
Low expectations (I don't expect too much") Some people are treated badly but I am lucky Compromise Putting up with what they're given Resignation I think it will always be the same here Quite happy used to the place.	Resignation/acceptance

Boredom Lack of activity Day long sitting here doing nothing Time seems long here you know I do nothing all day.	Boredom/lack of activities
Institutionalisation No choice Task routine Less activity with family routine	Environmental factors
Lack/loss of identity Lack/loss of autonomy Lost independence Don't like where I am Loss of individuality	Loss
Frustration Tired /worn out Denial I'm a survivor. Relocation stress Depressed	Coping/not coping

To maintain rigour and reliability, the raw data were further analysed by 2 experts. The independent experts are researchers who have expertise in narrative method, person-centredness, practice development and gerontology. They analysed the interviews and identified key themes using a thematic analysis approach. In total, the experts identified eleven key themes. The residents focus group, which consisted of eight residents who were part of the residents forum, was convened. This group discussed aspects of narrative that they felt staff should take account of when planning their care. Through these discussions they identified eight themes they felt were essential for good care planning. So in summary, I identified 12 themes, the CNM focus group 10, the experts 11 and the residents focus group 8. While there was a certain amount of overlap, the different groups sometimes used different words to describe the same aspect of care in the narrative. A comparative summary of these different analyses is presented in Table 4.

Table 4 Comparison of Themes Identified by the Four Groups

CNMs analysis	Researcher analysis	Experts analysis	Residents
Boredom/lack of activities	Being Occupied/ Importance of activities/ Past Interests	Boredom Hobbies/interests/ Activities	
	Fear	Fear for the future	Feeling safe
Coping/not coping	Maintaining Control Hopeless/ Helplessness	Frustration	Need for privacy
Communication (Staff & residents)	Connectedness	Contact with family/friends/ community/animals	Meaningful interaction with staff.
loss	Dependence/ Independence Health /Failing Health	Having to rely on others for assistance	Independence
Inadequate care /lack Of holistic, emotional care.	Staff Attitudes	Views on unit/staff perceptions	Knowing the staff
Resignation/ acceptance	Resignation	Need to relax/let go	
	Lifestyle	Restricted living /rules regulations	
Loneliness	Unfulfilled longing	Missing home	
Environmental factors		Areas for improvement/ environment	
Expectations	Status		To be involved In decisions. Having a choice
Contentment/ satisfaction		Contentment.	Knowing us/who we are.
	Hard Times		
	Life's work		
			Religion

Rigour

Data were subject to analysis as described earlier by a range of people from a number of different backgrounds –nursing, academia and residents. There was a high level of congruence between the themes identified. Additional rigour was attained by returning this data to an agreement focus group that I led and that consisted of the CNMs (n=12) for further discussion and refinement. The themes identified by the four groups myself, nurse managers, experts and residents, were merged and agreement was reached on common words to describe the themes. This refinement led to the final set of agreed themes. Ten themes were identified that were related back to the subthemes that had been identified in the original

Summary

This section, provides an understanding of the secondary analysis that was conducted with narratives from older adults in residential care settings. It describes the interpretative hermeneutic approach undertaken when using focus groups to analyse data and discusses the maintenance of rigour and reliability. The next section will outline the utilisation of this data in the conceptualisation of a framework of narrative practice.

Development of a Methodological Framework

This section outlines the development of a framework of narrative practice to be used in the assessment, planning, implementation and evaluation of care in residential care settings for older people. The way in which the framework was conceptualised with focus groups is described along with the frameworks relationship to the person-centred nursing framework of McCormack & McCance (2006). The section also sets out to identify the different elements of the framework and explain their use in practice.

Developing the Framework

Developing the framework involved mapping the agreed themes onto the Person-centred Nursing Framework. A participatory approach was undertaken where the CNMs took part in workshops and focus groups. Using information gathered from these focus groups (Appendix 12, questions 7-10) on what they felt was person-centred narrative practice and the key themes developed in the narrative analysis section, the CNMs aligned the agreed themes to the Person-centred Nursing Framework (McCormack & McCance 2006). They felt that the Person-centred Nursing Framework did not address the specific aspects of narrative that had been outlined in key themes identified in the Narrative analysis section. In order to confirm the relationship between narrative and person-centredness the participants firstly aligned the key themes with the constructs of the Person-centred Nursing Framework as set out in Table 6 below. At the end of this stage a detailed picture of the relationship between narrative and person-centredness was delineated.

Table 6 Alignment of Themes with PCN Constructs

Themes from Focus Groups with CNMs	Constructs of the PCN Framework (McCormack & McCance 2006)
Boredom ↓ Affects outcomes Satisfaction with care	Prerequisites Engagement Beliefs and values Sympathetic presence Care environment Appropriate skill mix Supportive organisational systems
Coping/Not Coping ↓ Affects outcomes Involvement with care feelings of wellbeing	Appropriate staffing levels Beliefs and values Sympathetic presence Providing for physical needs
Communication	Linked to all constructs
Loss	Beliefs & values Sympathetic presence Shared decision making Power sharing Effective staff relationships } Care Environment
Staff attitudes	Linked to all constructs
Resignation/acceptance	All of the care processes
Loneliness	All of the care processes Interpersonal skills
Environmental constraints	Working with beliefs and values Providing for physical needs All care environment
Expectations	All care processes All prerequisites Interpersonal skills
Contentment	All constructs.

This alignment proved a valuable step in assisting the participants with recognising the linkage between narrative and person-centredness, how narrative could inform person-centredness and it also allowed them to explore what aspects of narrative were missing from the original framework. While they recognised that the themes could be aligned to the constructs of the PCN framework, they also recognised that the narrative aspects of these themes were not specifically addressed within the PCN framework. The participants further aligned the themes to what they felt were narrative aspects of care and how this could be realised in practice and described three elements, narrative being, narrative knowing and narrative doing as three key areas that needed to be considered. This description was achieved by looking at what should be considered in practice to address the narrative aspects of care themes (Table 7) .

Table 7 Linking Themes to Narrative Aspects of Care

Theme	What could be addressed in a narrative approach to influence this theme?
Boredom	lack of activities
Coping/not coping	Fear, loss of control hopelessness & Helplessness
Communication	staff, residents, family and community, meaningful interaction with staff
Loss	Past status, past lifestyle, past abilities. Independence
Staff attitudes	Views on the unit positive and negative, staff perceptions Lack of holistic or emotional care, lack of privacy
Resignation/acceptance	Letting go, being able to relax
Loneliness	Unfulfilled longing, missing home, grieving.
Environmental constraints	Rules/regulations, restricted living, areas for improvement
Expectations	Conflicting desires, knowing the staff and the staff knowing me. choice, , being involved in decisions, valuing religion
Contentment/Satisfaction	Happiness, feeling safe.

Next the CNMs independently wrote on post it notes all the elements they felt needed to be considered. They then grouped these elements into areas of commonality and jointly agreed on the headings of narrative knowing, narrative being and narrative doing. (Table 8). Both the pillars and operational elements of this framework will be described in more detail in describing the framework section below.

Table 8 Flip Chart Exercise

How would staff use the framework in a narrative way.

Taken from Post it notes

Being

Communicating well with residents, families and staff
Working with privacy and dignity
Know what is important to the resident and work with that
Make sure the residents past life experiences and community involvement are part of accounted for in their care plan
Need to find out what the resident thinks is important
Residents views should be sought
We need to get the views of staff too

Knowing

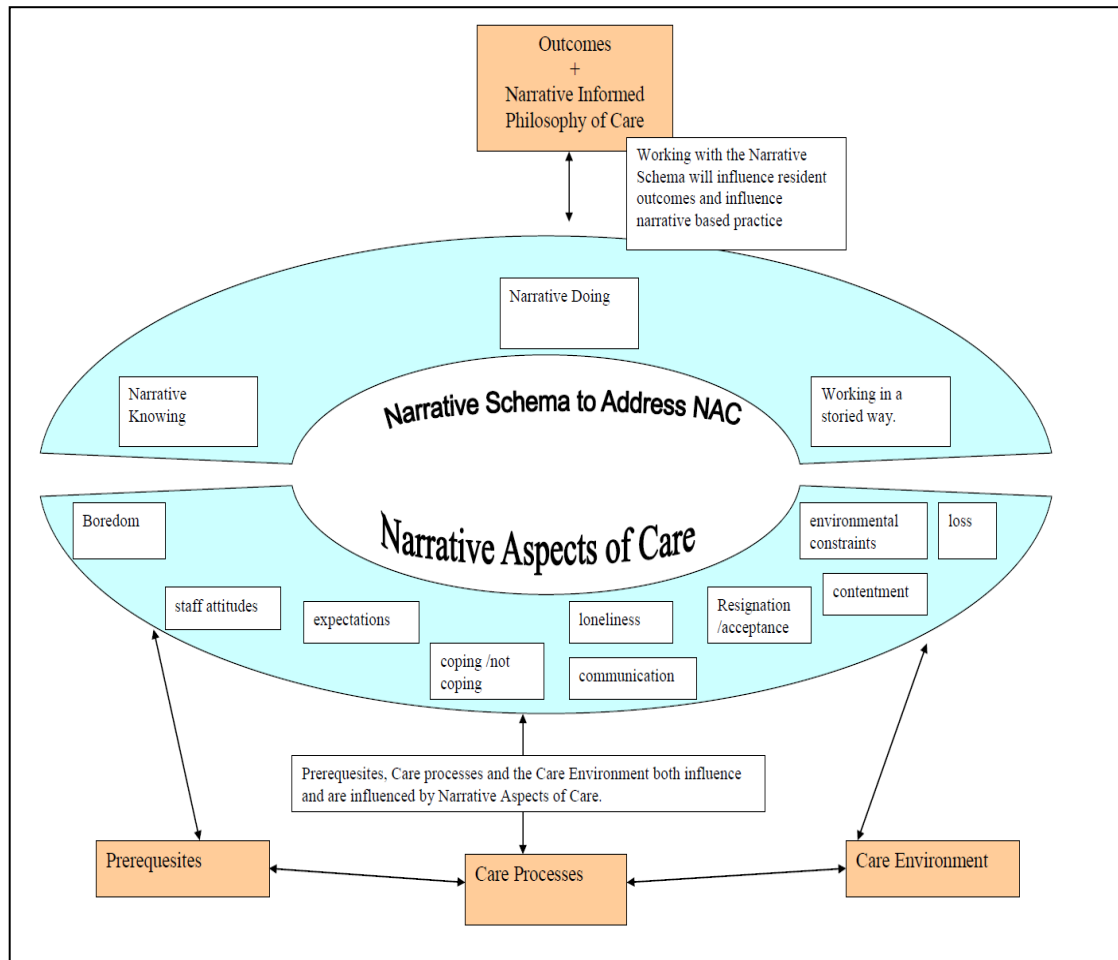
We need to know people's expectations of care
It is important to know who the person is this is the same for staff
Coming into care involves letting go of their old life we need to acknowledge that
Staff and residents should be equally involved in decision making
We need to ensure that everyone knows what safety is.
some people feel like they lose control when they come into care we need to Acknowledge and work with that
Loss of independence, loss of lifestyle loss of who they were

Doing

Meaningful activities
Activities should take account of past life
Should be able to continue with things they did at home
Residents should be able to attend the same events they did prior to admission
They should be involved in the running of the unit and any decisions that affect them
Lots of residents are grieving on admission we need to acknowledge and work with that

They also considered what the framework might look like and developed several rough drafts that took account of the PCN constructs of prerequisites, care processes and care environment and the narrative aspects of care as defined by the key themes. (Figure 4 and Figure 5).

Figure 4 First Draft of Framework of Narrative Practice



This first draft took account of the narrative aspects of care and the operational elements of narrative knowing, being and doing. However, staff felt that the narrative aspects of care should have equal status as the other elements from the PCN framework. For this reason staff proposed that a new framework of narrative practice be developed taking account of three constructs from the PCN Framework, prerequisites, care environment and care processes. They also proposed the addition of a pillar, specifically dealing with narrative aspects of care. Staff further

felt that the operational elements of narrative being, knowing and doing needed to be outlined in more detail taking account of the flip chart exercise (Table 8)

How would staff use the framework in a narrative way

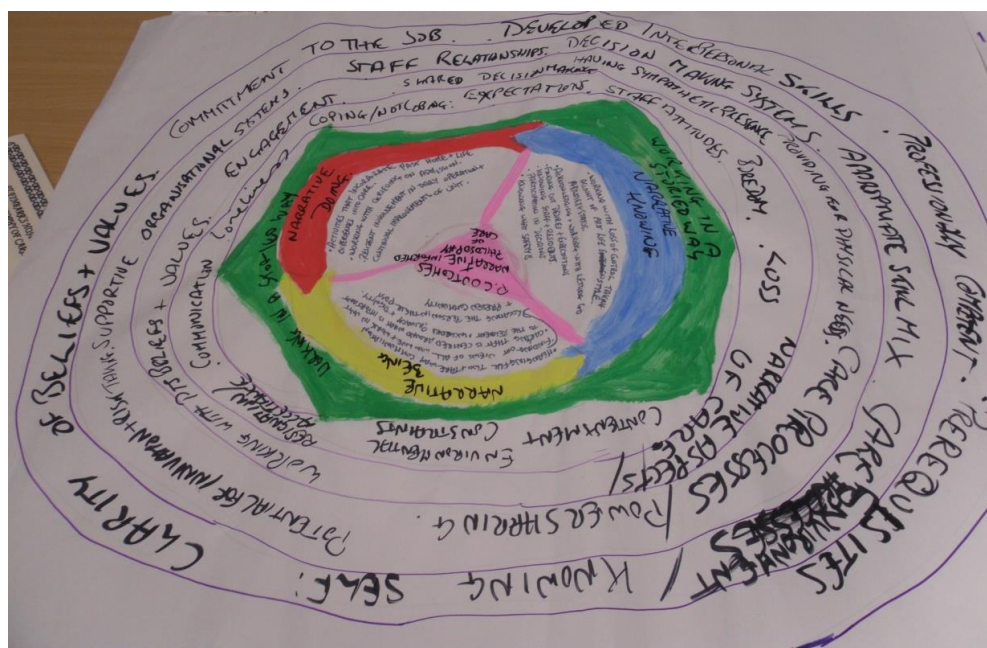
Further discussions about how this new framework could be implemented in practice using the question:

In what way or ways would you implement the linked framework?

led to participants identifying specific sub-elements under these three elements that would enable person-centred narrative informed practice to occur.

The discussion led to an outline development of a Framework of Narrative Practice (Figure 5). In keeping with maintaining rigour and reliability of the study, both myself and the experts also looked at this work. Thus, in the same way that the interviews were analysed by these three groups, the framework was further refined and developed by this group maintaining the collective process and the rigour of the development of the framework.

Figure 5 Outline Development of a Framework of Narrative Practice

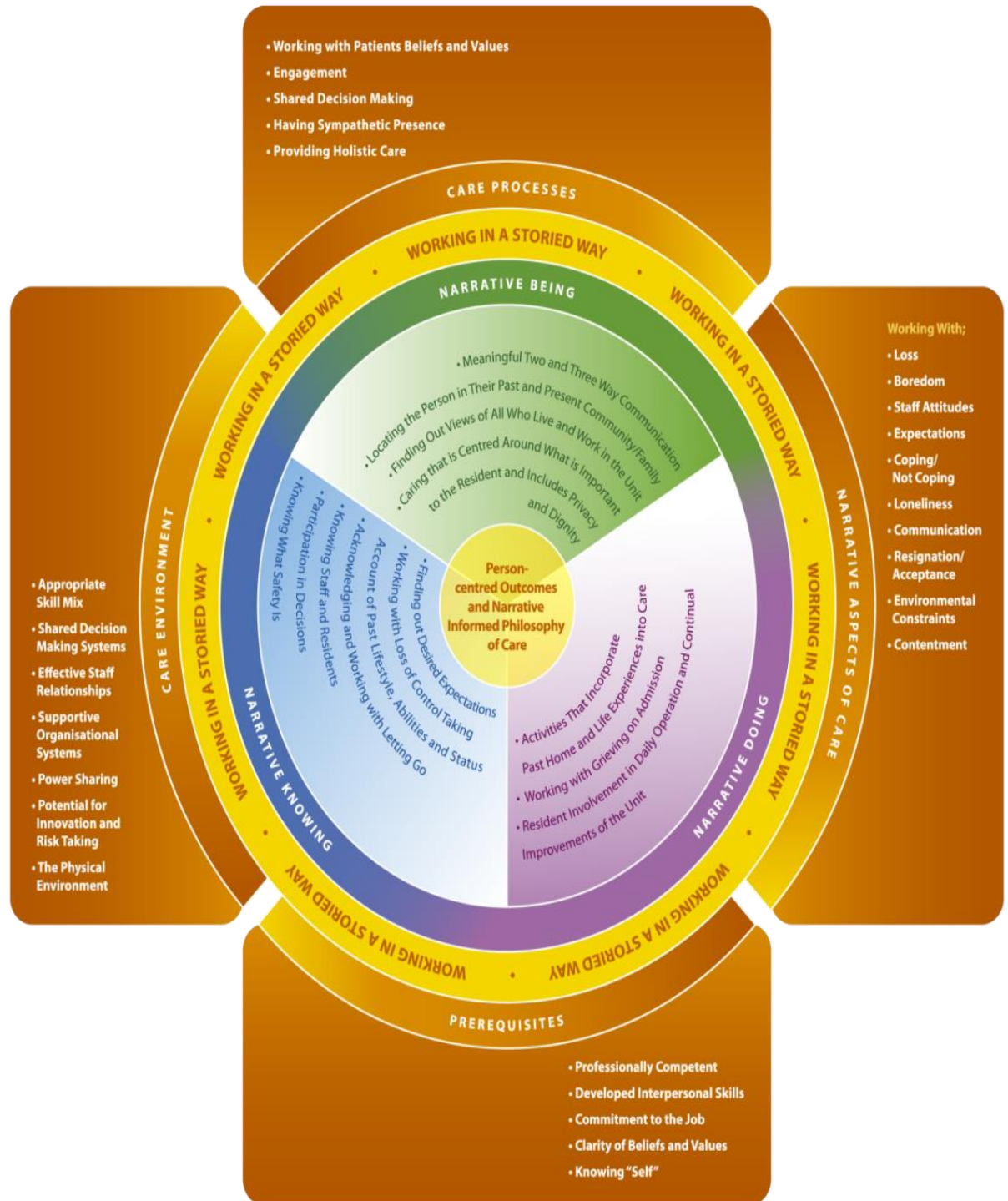


Describing the Framework

The pictorial representation (Figure 6) of this framework was further refined with the input of a graphic designer who worked with the ideas put forward by the CNMs,

myself and the experts. The picture indicates how the elements of the Framework of Narrative Practice provided both a base to build the framework on and the relationship that needed to be addressed between the different elements; supporting working in a storied way. The framework comprises four pillars, prerequisites, care environment and care processes (from the Person centred practice nursing framework, 2006) and narrative aspects of care (derived from focus group discussions with CNMs). These frameworks are the foundational underpinnings of the framework. By working with these pillars utilising the elements of narrative being, narrative knowing and narrative doing nurses can work in a storied way and ensure that person centred outcomes and a narrative informed philosophy of care is achieved. The development of this framework has already been published (see Appendix 13) for published paper.

Figure 6 Framework of Narrative Practice



(Buckley, McCormack & Ryan 2014)(Appendix 13)

Pillars

Prerequisites are the qualities ascribed to the professional expertise of the nurse. They focus on the skills nurses use to make decisions and on "knowing self" (Stickley and Freshwater 2002). Being aware of their own views can assist nurses in the development of open honest relationships with residents. These relationships acknowledge how these views can impact on the care experience (Cook 2006). The prerequisites pillar also focuses on the communication that occurs and specifies that the nurse must have good interpersonal skills.

The *care environment* pillar promotes person-centredness in an environment where culture change is promoted by facilitating transformational leadership, where practice is constantly being evaluated and where the organisation is willing to adapt according to the outcomes of that evaluation. The care environment pillar also recognises that shared decision making and change can only take place if supportive organisational systems are in place (Wilson 2005). Further, the pillar acknowledges the importance of culture and environment in facilitating person-centredness (McCormack & McCance . 2010).

Person-centred processes focuses on meeting the needs of the resident. This pillar deals with how care is delivered and how reflection and engagement are promoted. It focuses on meeting the needs of the resident through ensuring that a negotiated approach to care takes place between the nurse and the resident (McCormack & McCance 2010).

The prerequisites, care environment and person-centred processes pillars derived from the PCN framework have been described in more detail in Chapter 3.

Narrative aspects of Care. It is in this pillar that the value of narrative and "knowing" the person is explicated. The elements of narrative derived from the joint analysis inform this pillar. Working with the constructs described in this pillar, (loss, boredom, staff attitudes, expectation, coping/not coping, loneliness, communication, resignation/acceptance, environmental constraints and contentment), takes account of the rich tapestry that makes up a person's life, and encourages the development of a reciprocal relationship which allows the patient attain their full capabilities (McCormack & McCance 2010). Obtaining the life history of the resident helps

nurses attach meaning to the decisions people make with regard to life or care choices, and provides for an understanding of why people make certain decisions even if they are contrary to medical advice. By obtaining and incorporating the narrative biography of the patient into their care plan and utilising this information to aid with the assessment, planning, implementation and evaluation of care, nurses can obtain a clearer picture of how the patient would truly want their care delivered.

Operational elements of the framework

While the pillars represent the foundation of the framework, the operational elements of the framework are narrative being, narrative knowing and narrative doing. These elements are interlinked and to operationalise the framework aspects from each of the three elements needs to be considered. The pictorial representation (Figure 5), shows this inter-linkage in the way that each element melds and blends into the other. If staff take account of the pillars of the framework and the different processes under each of the elements, they will be working in a storied way. That is, person-centred outcomes and a narrative informed philosophy of care will be achieved. Narrative and narratives relationship to being, knowing and doing has been explained in more detail in both the literature review chapter (Chapter 3) and in the chapter outlining the theoretical underpinnings of this study (Chapter 4). However, in order to provide an understanding for the reader of narratives relationship to this framework and its proposed use within the framework, I will reiterate some of these understandings in the sections outlining narrative being, knowing and doing below.

Narrative Being highlights the importance of paying attention to and interpreting events, taking account of what happened in the past, what is happening now and what might happen in the future. Heidegger suggests if we want to understand the meaning of being we have to interpret the mode of existence of the entity (Taylor 1994). Essentially this means we that we must not only focus on the existence of the person but also on the context in which that existence occurs (Mackay 2005); that is, we have to know how our being is linked to the way we exist in the world (Heidegger 1962). He believed if we want to understand our experiences we must firstly understand who we are as thinking beings. Interrogating our existence helps us to understand the meaning of our being or our selfhood. Existence as described by Heidegger is that of a bodily active agent who is open to and vulnerable in relation to the world and who exists in time and has minimal control of its morality.

Ricoeur (1991) in his article on narrative identity describes being as the way in which we respond to change and act with others in a period of time. Narrative being is about interpreting the experiences of the resident by acknowledging that they are performative beings who like to communicate. The framework ensures that the residents' past and present community and family involvement along with their views of what constitutes a good quality of life are accounted for in their plan of care.

Narrative knowing is not just about lifestory and knowing that element of the person it is also about perception, recognition (of the person as a human being and what that signifies), reflections (on interactions and the way a person's life reflects the way they act or are) and shared understanding. Narrative knowing is about ensuring the identity or the 'I' that is rooted in the past is accounted for in the present time and is allowed to shape and build the future story of the individual (Polkinghorne 1988). It is possible that residents on admission to long-term care (LTC) don't foresee a future but everyone has one, often residents of LTC settings seek to deny their future by focusing on the past. This is a mechanism to protect the 'self' or the 'self-identity' as they know it (Hyden & Orluv 2008). It is the role of the nurse in these settings not only to ensure that the 'I' is protected but to enable the resident cultivate a new story one that includes their present living arrangements. Chinn and Kramer (2008) identify ways of knowing as "ways of perceiving and understanding", narrative knowing is a way of perceiving and understanding the story of the individual taking account of salient aspects of their present history but at the same time ensuring their past life status is also acknowledged. In this section of the framework, the residents' expectations of care are captured along with their feelings about their admission and their views on safety and risk.

Narrative Doing. (Action) relates to intentional action. Creating and maintaining meaning is at the centre of all human activity (Andrews et al. 2004) ie narrative doing is about ensuring that all activity is meaningful, has a purpose and provides an outcome for the participants. The outcome must have relevance to the problem or issue the narrator wishes to address. "Action implies goals" (Polkinghorne 1988 p.143), that is they are undertaken with the intent of accomplishing something or achieving an outcome. Narrative is the means through which that action is understood and made meaningful.

Activity is defined as action. Action in this instance is concerned with ensuring that appropriate conduct takes place when issues are identified or outlined. Polkinghorne (1998 p. 135) states that “the linguistic domain and the human order of meaning are organised according to hermeneutic rationality and aligned on various interactive levels” Based on this humans make decisions on what they want “to do” to attend to these needs and wants. Our past stories and experiences provide us with templates for how we take action in the here and now and also for the way in which the outcomes of these actions are linked to the way we intend to take action in the future. Narrative is the vehicle through which action is expressed and understood. Narrative doing is based on reflection and action. Actions taken based on information provided by the resident or their families about their past life experiences and also reflections on their current situation and their interactions with their present environment, are utilised with a narrative doing intention. That is actions/activities engaged in and organised with the resident are based on a mutual interpretation of the hermeneutic meaningfulness ascribed by the resident to both everyday and unusual activities ie grieving, admission, living arrangements etc.

“Action itself is the living narrative expression of a personal and social life”

(Polkinghorne 1988 p.145).

If carers take account of the pillars of the framework and work with the different processes under the operational elements they will be working in a storied way and person-centred outcomes and an narrative informed philosophy of care will be achieved.

Conclusion

The framework identifies a set of pillars to inform a narrative approach to care and three operational elements, narrative being, narrative knowing and narrative doing, that make it possible for staff to confirm the identity of the older person by taking account of their past life experiences. The framework not only provides staff and older people with a communication tool that can impact on the quality of care provided, but also ensures that care is individualised and specific to the person. The next chapter will outline the use of the framework in practice using an action research approach to implement the framework in a collaborative, participative way.

Chapter 6 Phase 2 Implementation and evaluation of the Framework.

Introduction

Phase 2, of the study, was concerned with implementing the framework of narrative practice in two research sites and evaluating the effectiveness of this implementation. The implementation occurred in two residential care sites over a period of 18 months, with work-based learning groups and an action research approach. Evaluation was both ongoing and time specific. Evaluation occurred continuously throughout the project. Work-based learning activities and culture identification undertaken by the participants were used in the development of the narrative ways of working. Data were also analysed at two time periods, mid-point (approx. 9 months after start of implementation) and at the end of the study, by the researcher and two experts. This was done to evaluate the effectiveness of the implementation. Both the implementation and evaluation will be outlined in greater detail in the upcoming sections.

Issues arising that impacted the study.

The CNMs were co-facilitators of the implementation of the framework. However, the differing management styles, engagement and values of the CNMs, impacted on the implementation. Their differing styles also defined the culture and had an impact on the outcomes of the project (Chapters 7 & 8). On one Unit 1, a particularly high turnover of staff due to reconfiguration, (30% year 1, 40% year 2) had both positive and negative impact on the project. Only a very small cohort of original participants remaining at the end of the project. The impact of this turnover will be discussed in Chapter 7 & 8.

Work-based learning groups.

The literature has found that classroom based education activities and formal education, that does not have a practice change component, does not benefit either workplace or patient outcomes (Williams 2010). For many nurses and educators, work-based learning is little more than training around skills and competencies. This training is seen as a way to improve the knowledge of the learners but does not impact the mind set of the practice setting (Gijbels et al. 2010). According to Manley et al. (2009), work-based learning has the ability to change the way care is delivered. These researchers believe that work-based learning, carried out within the context of a supportive organisational structure, and lead to organisational

effectiveness where both learners and patients flourish (Manley et al. 2009). A supportive organisational structure is one where resources are tailored to meet the organisational need and where collaborative learning is undertaken to achieve shared goals and promote reflexivity. Effective work-based learning, however, is not without its challenges. For most organisations moving from the traditional view of knowledge acquisition, knowledge translation and knowledge utilisation is difficult. A system where learners “soak up” learning in a classroom, return to practice and use that learning, without consideration for workplace context, is often the reason knowledge acquisition does not translate into practice (Manley 2009). Another reason cited by several authors, (Wright & Draper 2002, McCormack et al 2009, Manley et al 2009, Williams 2010) is a lack of recognition of the importance of skilled facilitation in supporting and encouraging learners to develop their own reflexive practice (Manely et a. 2009). According to Williams (2010), work-based learning has the ability to ensure that deep learning occurs. Learning, that can impact on the professional development of the learner and improve working practices. Further they believe that discussion, collaboration and reflection enhances the ability of WBL to improve the practice context, and change organisational cultures to ones where mutual learning occurs.

Insider/Outsider Facilitation Roles

In this study my role was that of an outside facilitator who had an inside perspective. Positioning myself thus, enabled me to understand the views of the researched Hellawell (2006). I was also to maintain a certain distance and to stand back and look critically at the practice culture as I am not embedded in it. Because I was not part of the workforce on the units I could look at issues with an outsider perspective but I was also cognisant of the problems the participants are dealing with. This, according to Labaree (2002), allows for a more critical observation of ‘unquestionable truths’ ones that insiders may not be able to recognise due to their proximity. Having a unique understanding of the working conditions of the participants, based on my role as the practice development facilitator on site, did provide certain insider advantages. Among these were the ability to be empathetic to the situations and working conditions of the participants. Further advantages were that communication was easy. Because of my prior relationship with the sites, there was an easy rapport which in a fully outside relationship takes time to build up (Hellawell 2006). This is demonstrated in the following data extract:

"think session today went very well, we are all very easy with one another and seem to work well together. Everyone is very open during the discussion, there is no awkwardness or reticence. I feel we are really able to get to the core of issues"

(excerpt from reflective journal 23/2/2012).

However, being an insider is not without its disadvantages. There were times when I felt staff took advantage of the fact that I understood their working conditions, and the pressures they were under:

"Mary rang today to again reschedule the session – this is the third time now and is getting to be a joke. I feel that she is taking advantage of me because she knows that I am aware of the staffing issues currently happening on site. It is not appropriate to continue changing dates just because I happen to work here. If I was coming in from outside would this be a problem? Would they also do this? I don't think so. "

(excerpt from reflective journal 16/04/2012).

The CNMs were inside facilitators with unique priori knowledge of the units and the people working and living there:

"This session is being led by Helen (CNM).... Throughout the meeting there is a good rapport and camaraderie between the staff and there is no evidence of a hierarchical structure. Everyone is able to voice their opinion without fear".

(excerpt from reflective journal 11/07/12).

Having the managers as co-facilitators was not without challenge. While the manager had unique knowledge of the participants, the participants also had unique knowledge of the manager. Often this impacted on the staff's participation. In one of the units where the manager had a hierarchical management style, the participants were initially very reluctant to voice their own opinions. This was compounded by the manager who also put her own spin on everything and often voiced her opinion prior to asking for the opinions of the participants. The managers style impacted on the way the staff engaged in the WBL sessions:

"Throughout the session even though we have discussed her role Mary [pseudonym] is constantly talking over the other staff and discussing particular residents and how she would like staff to be interacting with them.... States she would prefer to see staff having a meaningful conversation with a resident rather than washing a resident.....I can tell from the staff's reactions that this is not what is happening in practice but they appear afraid to challenge this....

(excerpt from reflective journal 29/05/12).

The approach used in the WBL groups will be discussed in more detail in further chapters. (Chapters 7 & 8)

Work-based Learning Activities Developing Action Cycles

After the Framework of Narrative Practice was developed, in the focus groups with the CNMs, and prior to getting a graphic representation of the framework designed, a meeting took place with the CNMs at the research sites. Both of the CNMs were met with separately. They were given an outline of the first programme day and provided with an outline drawing of the of the framework that had been agreed at the CNM focus group. These meetings were held in order to get feedback from the CNMs. The proposed framework, their role as co-facilitators in the WBL groups and logistical issues, such as time and location of the groups were discussed. Both meetings were positive, with both CNMs embracing the framework as something they both felt validated their participation in the focus groups. However both units had different concerns and different approaches to their involvement.

In unit 1, the CNM2 (Mary [pseudonym]), felt because of ongoing staffing constraints and the time commitment to provide the initial programme day, that it would be better if the process could be split into two separate sessions. While I understood the concerns raised I was initially worried that this would fragment the process:

“I am worried that splitting the programme day into two will lead to a fragmented process but I understand Mary’s concerns and appreciate that time and staffing constraints are at the core of this. I think how we get to this point is not as important as explaining the framework and helping staff develop ways to implement it in practice.”

(note from meeting with ward managers 22/9/2011)

However, I wanted to ensure the co-operation of the manager. We agreed that together we would look at the programme day outline and devise a new programme. The new programme would address the programme objectives and could take place over two sessions without being fragmented. This approach proved valuable, in getting the managers engagement, and also in gaining her participation in outlining programme days.

On unit 2 the CNM2 (Linda [pseudonym]) was finding the staffing constraints very difficult and also felt she was being asked to take on more responsibilities. She

suggested that her deputy, the CNM1 (Helen [pseudonym]), should be the unit lead in the WBL sessions. This was an unexpected turn for me, as one of the aims of the programme was to ensure the participation of the managers. However, Helen had taken part in all the pre-action focus groups and the development of the framework. She was equally as involved as the Linda in the day to day operation of the unit so I felt that this would not pose a problem. On this unit Linda felt it would be best to have the first WBL as a complete session. We agreed to commence the WBL at the same time as unit 1. Prior to commencement of the WBL, I initiated a meeting with Helen, on this unit, and we discussed the programme and her co-facilitation role.

On both units it was agreed that the WBL sessions would take place, on the unit, at approx. 11.15am. This seemed to fit best with the work schedule and would ensure that a maximum number of staff could participate. WBL sessions were scheduled to take place on a four to six weekly interval, with the participants undertaking WBL activities between sessions. The sessions were co-facilitated by the CNMs. A meeting was held with the CNMs one week prior to the WBL session to discuss both my role and their role as co-facilitators. While the CNMs co-facilitated the WBL sessions, they were also the driving force behind the implementation at unit level. Their role also involved ensuring that WBL agreed learning activities were carried out between sessions. The initial discussions with the managers did not involve what issues they felt the framework should address. It was felt that it would be more participatory, if the ward participants would use the framework to highlight and identify issues they felt could be addressed by implementing the framework. It was also important that all staff were able to identify the current practice, identify issues in relation to it, and outline what aspects of the framework could be used to improve this. Because action research's starting point may not necessarily decide how it continues and its intent is to be emancipatory (Roberts & Dick 2003), there was no preconceived agendas. Each day's agenda was built on themes derived from reflections on learning, from previous days, and work-based learning activities carried out throughout the lifetime of the project. This according to Heron (1999), allows participants influence processes that affect them. It is also in line with the principles of practice development which values active engagement and participation (Manley et al 2009). Below is an outline of how the agendas for the work-based learning days emerged. This will be discussed in greater detail in Chapter 7.

Table 9 Outline and Structure of Reflective Work-based Learning Groups

Purpose	Structure/Outline of Reflective Work-based learning group.	Processes used/ Data collection methods	Number of Participants at each session
Reflective Session 1 Getting to know the framework, and narrative aspects of care Agreeing ways of working	Overview of narrative in healthcare	Presentation and facilitated discussion	Unit 1 Nurse=4 HCA=2
	The development of the framework Linking the framework to PCC and PD how can this be achieved in practice?	Claims, concerns and issues. creative session with participants asking them to address metatheme Agreeing an engagement contract	Unit 2 Nurse=3 HCA=1 MTA=1
Reflective session 2 Critically looking at the current workplace culture	Re-engagement with Framework of Narrative practice with more in-depth explanation of narrative elements of care	Reflection on issues identified in Claims, concerns and issues	Unit 1 Nurse=4 HCA=2 MTA =1
	Working with claims concerns and issues from previous session	Creating a landscape of the workplace culture	Unit 2 Nurse=4 HCA=3 MTA=2
	Looking at observations of practice. Identifying how we can work with these observations to improve narrative practice	Identifying strategies to improve narrative practice.	
Reflective session 3 Identifying ways to promote narrative practice	Recap on narrative framework (any member of staff) and	Staff explain to others their understanding of the framework and how they would operationalise it	Unit 1 Nurse=3 HCA=2 MTA=1
	Interviews with residents/families or friends	Group work to look at interviews and identify key themes. Developing a shared vision for narrative practice Linking this to the CCI and observations from previous sessions	Unit 2 Nurse=4 HCA=1 MTA=2
	Relooking at and reflecting on claims concerns and Issues from day 1		
Reflective session 4 Using data collected to devise action plans.	Workbased learning activities how did they go and what were the outcomes.	Reflecting on learning and implications of identified practice	Unit 1 Nurse=3 HCA=2 MTA=1
	Looking at strategies from Day 2 and discussion from Day 3 and devising action plans to be worked on over next few sessions.	Development of an action plan	Unit 2 Nurse=4 HCA=2 MTA=1
Reflective session 5 Reflecting on where we are now and on	Recap on WBL activities How have reflections gone?	Reflecting, making sense of and working with the	Unit 1 Nurse=3

going forward	How did interviews with relatives/residents go? Have they been completed?	data collected and looking how this informs action cycles	Unit 2 Nurses=3 HCA=1 MTA=1
	Feedback on Informal ward meeting Feedback from CNM Action planning. Discussion and further work	Getting a sense of taking ownership of actions Strategies to overcome difficulties and maximise benefits of action plans	
Reflective session 6 Making the framework real	Recap on Framework	Making the framework real using it in everyday language and continuing to build knowledge of how the framework works	Unit 1 Nurse=4 HCA=1
	Recap on WBL activities Discussion on the data from Documentary analysis Development of a prompt sheet for nursing documentation to encourage people to document in a narrative way Action planning. What has been achieved? And how?	Gain an understanding of how to use data collected Looking at what you see happening/the way things are being done in the analysis and how things should be done Reflecting on learning and implications for ongoing activities, including the further development of action plans	Unit 2 Nurse=3 HCA=1 MTA=1
Reflective session 7 Spirals and actions	Recap on activities since last day. Group reflection on how/if the framework has improved practice. Spirals from action cycles looking at other activities that have arisen Looking critically and tweaking documentation prompt sheet Sustainability and going forward	Reflective practice What is it? How to get the team involved? What do I do with mine and others reflections? Facilitated discussion on ways of improving the documentation sheet	Unit 1 Nurse=3 HCA=1 Unit 2 Nurse=3 HCA=1 MTA=1
	Reflection on WBL since last session Evaluation of taking part in study	Creative exercise to determine how everyone felt about taking part in the research project and to look at the changes in	Unit 1 Nurse=5 HCA=1 Unit 2 Nurse=3

		practice?	HCA=2 MTA=2
Reflective session 9 Celebration	Celebration of achievement	Celebration event involving all who work and live in the unit. Celebration to focus on an aspect of practice that has change/improved since implementation of framework of narrative practice	

Overview of Data Collection Methods

All minutes, field notes, interviews, observations and reflections from the work-based learning groups formed part of the data collection and were constantly reflected upon throughout the life of the project. The different methods of data collection that took place on each of the units is set out in Table 10.

Table 10 Data Collection Methods

Data Collection Methods	Participants	Unit 1	Unit 2
Interviews	Nurses and HCA/MTA	2 Interviews x 20-30 minutes	5 Interviews x 20-30 minutes
Observations of Practice	Nurses HCA/MTA	2 x 20 minutes	6 x 20 minutes
Work-place Culture Context Assessment Tool (WCCAT)	Researcher Nurse	2 x 30 minutes	2 x 30 minutes
Field notes/Reflective Diary	Researcher	9 reflective notes	9 reflective notes
Minutes/notes of Work-based Learning (WBL) groups	Researcher Nurses HCA/MTA	9 WBL minutes	9 WBL minutes
Reflections	Researcher Nurses HCA /MTA	4 reflections	4 reflections
Documentary Analysis	Researcher	10 charts (5 at time 1 5 at time 2)	10 charts (5 at time 1 5 at time 2)

Interviews with older people, family and friends

Interviews were undertaken, in order to ascertain the lived experience, of those living and visiting the site, and were consistent with the narrative methodology of the study. According to Mishler (1991), paying attention to the stories people tell, can help us examine our practices. Therefore, stories are a good method to use in a practice development approach, to help us determine the lived experience. They can also stimulate reflection, and help us identify areas where change may be needed. According to Rapley (2004), interviews are interactions, where those involved cooperate to produce linguistic accounts, that are either based on past experiences or future intentions. Some researchers would argue that interviews do not accurately reflect an experience, but rather give meaning to that experience, because they compel the interviewee to reflect on the experience thus giving it meaning (Ferber 2000). As this research wanted to elicit the experiences of the interviewees it was considered appropriate to use interview as a method of gaining this information. Rapley (2004), suggests interview is an ideal means for researching people's experiences in a social milieu. Interviewing was also seen as a method of increasing engagement between staff, residents and families. All staff were invited to conduct interviews using open ended questions, and an interview guide (Appendix 14) to help with the flow of the discussion. Interviews with residents were conducted by staff on both units as part of their work-based learning activities. At the work-based learning sessions staff were introduced to the interview guides, and instructed on how to conduct an interview. Staff found this a difficult activity to complete. Reasons cited were; residents unwillingness to take part, difficulty meeting relatives as they did not visit at the time staff were on duty, monosyllabic answers, and not having any extra time to complete. Therefore, on unit 1 only two interviews were completed and on Unit 2 five interviews were completed. Each interview lasted approximately 20-30 minutes. Data gathered from the interviews was used by the work based learning groups to critically reflect on the workplace culture and the care practices. This analysis helped the staff develop action plans, that were focused on issues identified by those who lived on the units. This data were also used in the overarching evaluation as discussed in Chapter 8.

Reflective practice.

Reflection in and on practice can ensure that learning that occurs is meaningful to practitioners (Kemp & Baker 2013). Knowledge gained in this manner is both interactive and context specific. Practitioners, using reflection in/on practice, can draw on their own previous experience and personal knowledge, to reflect on the current state of the practice setting. The concept of reflective learning is firmly entrenched in nurse education programmes, and its benefits have been widely reported in the literature, (Schon 1987, Freshwater et al. 2008, Boud et al. 2013). Bulman et al. (2012), explored post graduate nurses experiences of reflection in practice. The researchers found that the process of reflection was one where nurses were searching for an answer to a practice issue or problem. Similarly, Johns (2009) and Jasper et al. (2013), discussed moments of being connected to ourselves and others, by engaging in reflective moments. These reflective moments enable us gain insight, into both our own and others experiences, and existence. However, this may not be typical of most nurses in a practice setting. There continues to be a need to encourage practitioner to look at their practice, reflect on that practice, and formulate ways that could improve it (Lea & Callaghan 2008, Braine 2009). There is evidence to suggest that practitioners do not reflect in a critically analytical way (Lockyer, Gondocz & Thivierge 2004). This has led to inconsistencies between knowledge acquisition and knowledge translation/utilisation. (Lockyer et al. 2004). Reflections, both in and on practice and personal critical reflection, have long been advocated as a method of professional and personal development (Kolb 1984, Schon 1987, Rolfe, Freshwater & Jasper 2001, Boud et al. 2013). However, reflection and reflexivity require a significant amount of input, both intellectually and mentally, from those who may not have time, or commitment to adopt this method of development (Raelin 2009). A total of four reflections from each unit, along with the my own reflective notes, were part of the data set. Reflections on ongoing activities and current workplace culture, collected on work-based learning days, also formed part of this data set. These activities will be discussed in more detail in the subsequent sections

Field notes/reflective diary

Further to completing reflections, when issues or concerns occurred within the research project, I also completed field notes and maintained a reflective diary throughout the study. Field notes are objective records of observations that occur during particular research activities (Newbury 2001). Using reflective field notes in

qualitative research can facilitate reflexivity. It can also help the research clarify their personal values and beliefs. During this study I kept detailed field notes after each work-based learning session and a reflective diary where thoughts and observations on the research process were recorded. Both the field notes and the diary were valuable tools for critically reflecting on issues that arose in the research and also in identifying the overall evaluation of the implementation in the practice setting. A total of eighteen reflective notes, nine for each unit were completed.

Observations of practice

Observations of practice were carried out, using both an adapted form of the 'Workplace Culture Critical Analysis Tool' (WCCAT)(Appendix 15) (McCormack et al. 2009), and observations of practice from Participants Resources, Practice Development School (Dewing 2005). The observations were in effect both a learning activity and a method of evaluating change. The participants carried out observations of practice (Dewing 2005) in order to identify their present culture, and used these observations as a method of looking at areas where change needed to take place. Staff, both nurses and HCAs, conducted the observations which lasted approximately 20 minutes (Unit 1, n=1 and Unit 2, n=4). I also conducted structured observations, using an adapted form of the Workplace Culture Critical Analysis Tool (WCCAT). These observations were carried out, together with another member of staff, who had been trained in completing observations, using this tool, on both units at the midpoint and end of the study. These observations lasted approximately 30 minutes. This, according to Reason and Bradbury (2008), allowed for an emergent process, one where the data generated informed the actions taken.

The WCCAT is a formal evaluation tool that looks at both the culture and context of the care environment by focusing on eight areas: physical environment, communication, privacy and dignity, patient involvement, team effectiveness, learning culture, risk and safety and organisation of care. The WCCAT allows for a more in-depth critical analysis of the workplace culture, because it allows observers to look at the superficial, middle, and deep levels of culture. In this way it allows practitioners step outside their everyday practice, to look critically at the setting, and the way practice occurs. This reflection informs practitioners of areas where change can improve the culture, and context of care (McCormack et al. 2009). This study was concerned with looking at the way the narrative of the resident was used

to inform and plan their care, therefore, the WCCAT was looked at and adapted, solely for the purpose of this study, to include narrative aspects of care (Appendix 15 adaptations shown in red). The adaptation was carried out in each of the 8 sections, by relating that section back to the framework of narrative practice (Figure 5 p.110). The information in the framework was used to formulate prompt questions for the adapted WCCAT (Appendix 15). The adapted WCCAT was critiqued by the original author of the tool, and by an expert nurse in older adult care. Comments and suggestions received were used to refine the tool. Observations using the adapted WCCAT were conducted at two time points during the study. T1 occurred mid way through the study and T2 occurred at the end of the study. The purpose of these observations was to see if the implementation of the framework of narrative practice affected the way care occurred in an observable way in the units. The adapted WCCAT was used at two time points in the study, to evaluate midterm progress, and overall effectiveness of the implementation of the Framework of Narrative Practice. The analysis of this data will be discussed in more detail in the findings and evaluation chapters (Chapter 7 & 8).

Documentary analysis

Documentary analysis is a process of looking critically at documentation to ascertain if it provides evidence of the process and way care is carried out (Owen 2005). In this study the nursing care planning documentation was analyzed using a documentary analysis tool. A documentary analysis tool (see Chapter 8 p.179) was developed by the researcher based on the methodological framework of narrative practice (Figure 5). Using this tool I conducted documentary analysis on 10 resident care plans. Five at time one and five at time two on each unit. This tool was used to conduct an analysis of the nursing notes, to ascertain if elements of the framework were being used in practice, and to evaluate the effectiveness of the framework. Data collected from this analysis was used, to inform the work-based learning groups of changes that needed to take place, how these were developing, and in the overall evaluation of the implementation of the framework of narrative practice. The development and utilisation of the narrative analysis tool will be discussed in greater detail in Chapter 8. The use of the tool in the overall evaluation of the programme will also be discussed in Chapter 8.

Conclusion

This chapter sets out the structure of the programme days that were undertaken, using an action research approach, to implement the framework of narrative practice. It provides an outline of the data collection methods used when gathering data, for both the ongoing evaluation of the implementation, and the overarching evaluation. Further, it explicates the rationale for using an existing set of interviews to form the basis of this analysis, and discusses the development of the Framework of Narrative practice. In Chapter 7 the findings from this data collection will be discussed taking a case study approach.

Chapter 7 The Story of the Implementation of the Framework.

Introduction

The implementation of the framework took place over a period of 18 months. A total of nine reflective work-based learning groups took place on each unit, approximately every 2 months over the course of the study. These reflective groups are already outlined in chapter 6 (Table 9). However, in this chapter a further graphic representation will be presented, outlining the relationship of particular days to the development of each action cycle. The project started out with the intention that the two units would implement the framework at the same time. However, due to problems with access on one of the units and issues related to staff turnover, the implementation and development of action cycles happened at different times on each of the units. This in turn meant the way the units engaged with the sessions and the action cycles that emerged, was very different on both of the units. To illustrate the engagement of the units in the implementation, this chapter will be written taking a case study approach. Case study according to Flick (2011), allows for a more purposeful and infinite comparative analysis of the lived experience and problems identified. A meeting was also held with the managers one week prior to each session to discuss and negotiate their and the wards participation. Continued unit engagement was achieved by outlining a basic agenda for sessions at the end of each work-based learning session. While there were differences, there was also some overlap in the way participation occurred. This will be outlined, firstly, prior to discussion of the individual units participation in the case studies.

Getting to Know the Framework and Narrative Aspects of Care

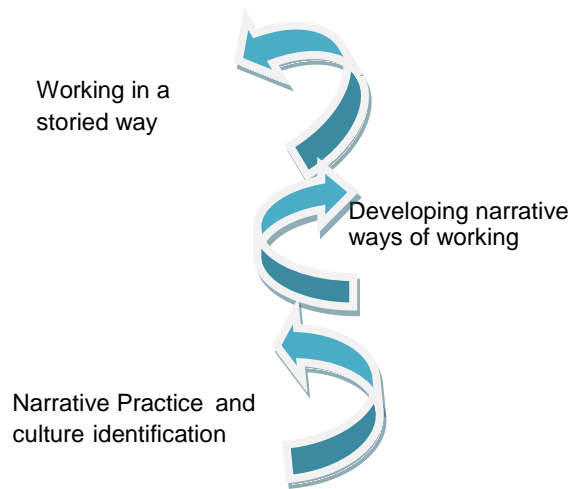
The first session on both units started by collectively agreeing ground rules for the way we would work together in the group. The ground rules very simply were:

- being open and honest
- respecting others and their viewpoint
- sharing experiences and being positive.

Staff were given an overview of the approach that would be taken in the work-based learning groups, and also the expected time frame of the project. The structure of the case studies was based around three cycles (Figure 6). Essentially these were, **narrative practice and culture identification, developing narrative ways of**

working and working in a storied way.

Figure 7 Action Cycles



However, within each unit and with differing degrees, smaller spirals of action also occurred and these will be described within each case study.

Identifying the culture and gaining an understanding of the framework of narrative practice was an ongoing exercise throughout the life time of the study. At the beginning of the study (sessions 1, 2 & 3), it was important to identify the present culture, and the basic assumptions that both staff and residents held about how care was carried out. This was essential so that staff could identify what an effective culture was. This according to Manley et al (2011), is an important priority for all healthcare providers and essential if transformation of the workplace is to take place. The first three reflective practice sessions as outlined in table 11 were devoted to gaining an understanding of narrative use in practice and identifying the present culture. Staff employed a number of methods to do this, namely; creative expression, interviews with residents and observations of practice. Data gathered from this exploration were analysed and utilised to form the basis of developing action plans. This analysis and the resultant outcomes will be discussed in detail within each case study. Throughout the process staff utilised the framework of narrative practice to inform their discussions on identifying culture, developing strategies, and working in a storied way. They took account of both the pillars of the framework and the operational elements in all their learning activities.

Sessions 4 and 5 (Table 14) were devoted to reflecting in and on practice and making sense of the workplace culture in relation to the identified practice. Schon (1987), identified this as being able to critically look at the way practice is occurring and discovering what evidence is underpinning that practice. This process encouraged the staff to look at the way things were happening in their setting, to critically examine that in light of their own experiences, their current knowledge and how it related to the Framework of Narrative Practice. They next looked at how improvements could be made taking account of the identified current practices. Thompson and Thompson (2008) describe this as, reflection on action, where practitioners look at events after they happen and analyse that event, identifying areas of good practice and areas where improvements could be made. These sessions focused on using the collected data to devise action plans that the units would work on implementing throughout the life of the project.

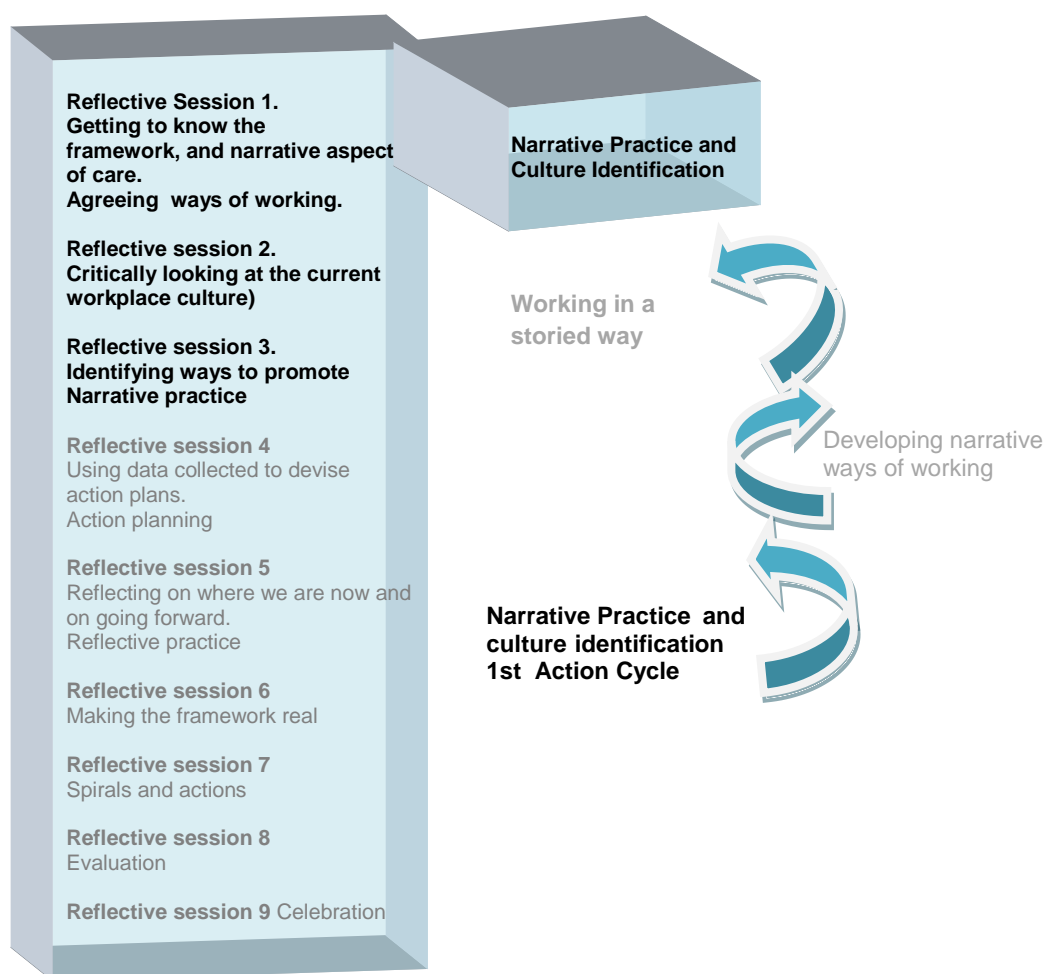
For the rest of the reflective sessions (Table 17) the units were concerned with looking at how to implement, or make real, the framework in practice. They did this by developing action plans that addressed specific aspects of narrative practice they had identified were lacking in their own setting. Action plans are specific, measurable and achievable goals that are agreed collaboratively and are owned by all involved in their development (O'Neal & Manley 2007). They usually identify who is responsible for each stage of the implementation, specific timeframes for achievement and what resources might be needed to achieve their implementation. Both units approached this in different ways and this will be explained in further detail within the case studies.

Along with further developing and implementing the action plans, sessions 7 and 8 were also concerned with sustainability and going forward. Both units looked at ways to continue to build on the learning from the project, and further develop their practice in a critically reflective way. Sustainability is an important consideration when implementing a practice development project. However, sustainability is often overlooked in favour of quick fix approach (Spencer, Unsworth & Burke 2001, Manley et al. 2013). Oftentimes, there is no consideration for the ongoing uptake of the change or its adoption by others. Quick fix approaches are often attractive to managers, and little or no worry is given to sustainability. Sustainable change,

where practitioners are involved not only in problem identification, but also in identifying underlying culture, leads to teams that are proactive in developing and changing practice (Manley et al. 2013).

Narrative Practice and Culture Identification

Table 11 Narrative Practice and Culture Identification



Narrative practice and culture identification was concerned with looking at the present culture and identifying the way practice was currently happening in the units. Staff critically reflected on the ways they were engaging with the residents and on the way care was planned and implemented. They used creative media, during the reflective work based learning sessions, such as collage, painting and poetry to express what they saw and felt about the current culture.

Case Study Unit 1.

The initial engagement of this unit with the project did not go as planned. The opening work based learning reflective session was rescheduled 4 times prior to it eventually taking place. There were a number of reasons for this, staff constraints, new admissions putting pressure on time, changes in staff complement and once because of my need to attend a seminar that I was not aware of prior to agreeing to the date for the session. Mostly when these sessions were rescheduled it happened at short notice, usually with a phone call from the CNM on the morning when the session was to occur. This made me very nervous and unsure about the desire of the staff, and indeed of the CNM who had agreed to co-facilitate the sessions, to participate in the project:

M. rang today to again reschedule.... . I am now very concerned that they will fall behind and that I will have moved so far ahead with unit 2 that I will have trouble focusing on Unit 1 and the stage they are at. I am beginning to also think that maybe they do not want to be involved despite their initial willingness.....

The idea initially was that both sites would progress at the much the same rate, this is not happening and makes it more difficult...

(excerpt from reflective journal 4/4/12)

In an effort to prevent this having a negative impact on the implementation on this unit, I arranged to meet with the CNM again and to discuss any concerns she was having. I also inquired if changing the times of the sessions would be beneficial in enabling staff to attend. The CNM responded that she did not have any concerns about the study but that staffing issues and time constraints were the problem. She also stated that changing the times of the work-based learning sessions would not be beneficial, as this was the best time to ensure staff involvement, as had been previously agreed.

When the first session eventually took place the staff on this unit were very enthusiastic and engaged. This was a relief and gave me hope that the further implementation would go smoothly. The staff critically looked at the framework, and then used creative methods, (painting, drawing, writing poetry), to identify what narrative aspects of care meant to them, and how they could achieve this in practice. These methods are explained more fully in Chapter 6. They explained their creations to the main group. All themes were collected and key themes were

extrapolated by the group. They looked at the identified themes and discussed ways narrative practice could be achieved. Key themes were identified and staff used these themes to form the basis of identifying their present workplace culture (Table 12).

Table 12 Narrative Aspects of Care Key Themes Unit 1

What do narrative aspects of care mean to me?	How can this be achieved in practice?
Communication Could be non verbal Figuring that out Knowing your patient Everything follows from it Getting down to residents level intellectually everything follows on	Having time to talk Gaining trust Knowing you're here to help Certain time of the day you could focus on that
Time To sit and talk with somebody Making that important	
Non task orientated	
Giving comfort	
Privacy	Ensuring that when you are doing tasks you are also talking Planning organising day Need to prioritise most important Knocking /curtains/door/using presence lights
Confidentiality	
Commitment Being genuinely there Not watching clock Commit for a length of time	
Providing for their needs Drink and food	
Acknowledging Resident Saying good morning	Discussions remain in confidence Be aware of how you talk about residents in the corridors or in conversations you have with others 1 st thing in the morning very important to gauge mood Give resident chance to give you information in the way they want to give it. Ensuring the way the resident interacts with activities that happen on the ward is captured
Shine a light on the person/their life	
Down a hole Helping them out of difficulties people have – loneliness, loss , sadness, physical contact, sexuality, privacy Loss of adulthood	

The themes that emerged were communication, time, non task orientated, giving comfort, privacy and confidentiality, commitment, providing for residents needs, acknowledging the resident, shine a light on the person's life and down a hole.

Communication

Communicating, talking, engaging and promoting interaction were all discussed as areas that could promote knowing the resident and that encouraged the development of trust. Communication was highlighted as a means of engaging with the resident on their level. This related to the narrative aspects of care, and care processes, from the pillars of the framework of narrative practice, and narrative being from the operational elements. In their identification of themes several staff expressed the importance of communication as a means for getting to know the residents and as a way of engaging in narrative practice:

"....will give us the enabling information to help the residents more effectively."

Participant HCA

".... will improve our awareness of residents' needs"

Participant Nurse

They spoke about 'verbal and non verbal' methods of communication and the importance of knowing when either verbal or non verbal means of communication were needed:

"A lot of the time we rely on nonverbal methods of communication..... it is really important to be able understand the different non verbal ways of each resident"

Participant Nurse

They stated that 'knowing your patient' or the person behind the resident and seeing them as a vibrant individual, contributed to communication:

"Sometimes we don't use the residents lifestory when we plan care... knowing more about them and their likes and dislikes can help us plan better and make the care more individualised"

Participant Nurse

Ensuring they got 'down to the level of the resident 'intellectually' and were able to see things from their perspective could assist in ensuring that good communication was taking place:

"Good open communication promotes engagement between residents and staff"

Participant Carer

This helped with gaining trust and letting the resident know they were 'here to help'. Furthermore, everything else followed from this. All other care episodes could be influenced by how communication was carried out and this could be either negative or positive:

"My picture is about communication its not only verbal it could be about non verbal also and it really is about knowing who the person is in front of you"

Participant Nurse (explanation of creative image)

Time

Staff considered both the time pressures they currently practised under and the effective use of time when looking at narrative aspects of care. Time was connected to both narrative being and narrative doing. The current culture within the ward was one of not using time in an effective way with the residents. While staff acknowledged that they were under constant pressure to complete tasks, however, in their creative expressions they did not focus on time pressures or having difficulty because of lack of time. Instead they focused on the importance of using their time wisely and effectively to ensure residents were being given time to express their needs and wishes in accordance with the care processes and narrative being of the FNP:

"We need to look at how we are doing things and make better use of our time..."

Participant HCA



Time to just sit and talk to residents was highlighted as a way of gaining information that could be used to inform the care the resident received. However, staff stated

that this may not be seen as a good use of time or privileged in the current culture of the ward. Staff stated, it was important for everyone to see that time used in this way was essential and should be privileged as it could make a difference to the quality of life of the resident:

"if someone is upset and not wanting to have a shower we should be able to take the time to talk to them and not feel under pressure to get on with it or worry about what others will think"

Participant HCA.

Non Task Orientated

Non task orientated aspects of care focused on changing the culture to one where tasks were not privileged or seen as more important than the resident. This theme was closely aligned to time and time pressures. It also related to narrative being. The prioritization of tasks and tasks that were centred on the resident were the focus of this theme. Staff expressed the wish to move to a culture where tasks were replaced by organising the day around what is important to the resident. This, they felt would ensure that care did not focus on tasks but focused on the person:

"it should be ok to set aside the tasks in favour of doing something meaningful with the resident, this would surely improve their quality of life.....not sure we are doing that now...."

Participant Nurse.

The present culture was identified as one where tasks were seen as important and there was pressure on staff to ensure that all tasks were complete. Staff also stated tasks were often prioritized over ensuring the wishes of the resident were acknowledged. While certain tasks had to be complete these could be used as a means of engaging and communicating with residents. Cleaning and care tasks in particular were highlighted as areas where this could occur:

"it is important to acknowledge the person when you doing things in the room like the cleaning.....you can have a bit of a chat as you go along"

Participant MTA.

Giving comfort

The theme giving comfort focused on maintaining the emotional wellbeing of the resident by ensuring that staff offered comfort when the need arose. Giving comfort was an area that was not well developed in this unit. This was reflected in the

narrative knowing section of the framework and also in the care processes. Discussing comfort and in terms of both physical and emotional well-being, staff aligned it closely to time and time pressures:

"Residents often have emotional problems that we don't take the time to deal with because we are often under pressure trying to get the work done"

Participant Nurse

It was important to staff that they had the ability to take time to acknowledge when residents needed comforting and were able to offer comfort if needed. However, they conceded they were currently not doing this very well. It was acknowledged that knowing the resident and their history would enable them recognise when the resident was uncomfortable and also help them with strategies to alleviate that discomfort. They expressed this in terms of having a connection or in depth knowledge of the person:

"if you know what makes them tick it's easier to find out what's bothering them"

Participant HCA.

Privacy and Confidentiality

The privacy and confidentiality theme was based on both ensuring that residents individual privacy was maintained and the need for staff to treat resident information as confidential. Privacy for the staff clearly centred around the narrative being operational element of the framework, they spoke about care that centred around what was important to the resident and that was mindful of their privacy. Pictures drawn by staff showed there was a lack of privacy and confidentiality for residents in the unit and they acknowledged that the area of privacy was very important for the resident. Strategies discussed to enable this were; ensuring they knocked on doors when entering rooms, and being mindful that curtains were drawn and doors closed when they were attending to care. The more frequent use of presence lights, as a way of alerting others that care was occurring in the room and preventing interruptions, was also seen as a method of maintaining privacy:

"using the presence lights would let everyone know that we were doing care and there would be less interruptions...."

Participant HCA



While they identified these as important areas they also acknowledged that this did not always happen. Closely related to this was the need to ensure that all discussions with the resident remained confidential unless the resident wished others to know. The creative expressions highlighted that inappropriate conversations were taking place, where often the personhood of the resident was not acknowledged, and that frequently these conversations were not confidential. Discussions centred on the need to be aware of how they spoke about residents in the corridors, or in conversations with others. Staff stated these discussions should be respectful but also they needed to ensure they maintained the confidentiality of the resident:

"I'm often shocked by what I hear people saying in the corridors.....sometimes it is not very nice"

Participant Nurse.

Commitment

Commitment in relation to narrative practice was expressed as the need to be genuinely there or present for the resident. This linked with staff attitudes from the narrative aspects of care and with having sympathetic presence from the care processes pillars. Staff expressed this as being able to commit to the resident for a period of time, and not to be seen by the resident as watching the clock waiting for the time they could disengage. The way staff expressed their interaction with the residents showed they were committed to establishing and maintaining relationships and to spending time with the residents. This was demonstrated in the creative

pieces as episodes of coming together. Sometimes, however, there was a lack of commitment by staff to engage fully in these episodes making them fleeting, transient occasions and non fulfilling interactions for the residents:

"sometimes it is hard to be fully there for the resident when you have other things on your mind..... my picture shows how we should be fully giving our attention to the resident when interacting with them and not rushing on or thinking about the next thing we have to do"

Participant Carer

The need to be available both physically and emotionally for the resident, while at the same time being mindful of protecting themselves was further highlighted. Staff felt this commitment could be expressed through physical actions and expressions but also by ensuring residents were aware that staff were available if needed:

"you need to give your full time and attention to the person when you are caring for them.....it is important that they don't feel rushed or that you are in a hurry"

Participant HCA

Providing for residents' needs.

The theme providing for residents' needs highlighted how being aware of the ability, likes and dislikes of the resident was important to ensure they received the care they needed. This was associated with both the care processes and narrative being elements of the FNP. In their expressions, staff outlined that sometimes the care provided did not match the desired expectations of the resident, and that this was particularly evident around the dining experience:

"Often we cannot give the residents the things they would have had at home...mealtimes in particular are not always as the resident would like them to be, choice is often limited and not always appealing....."

Participant Nurse



Discussions around this theme mainly focused on meals and mealtimes and on ensuring residents who needed assistance were helped when they needed to be. Staff discussed how using the narrative framework would enable care to be centred on what is important to the resident and could also assist them to identify the residents preferred ways of being assisted:

"Narrative practice will improve our awareness of residents' needs"

Participant Nurse

"When we have an in depth knowledge of the likes and dislikes of the resident we will be able to plan care that is centred around the person"

Participant Nurse

Acknowledging the resident.

The importance of acknowledging the resident was identified as an important way of validating the personhood of the individual and also of showing camaraderie and friendship. Acknowledging the resident was closely linked to both communication in the narrative aspects of care pillar and providing for residents' needs in the narrative being and narrative doing elements:

"it doesn't cost much to say hello and be friendly to the residents"

"It improves the atmosphere and makes it a nicer place to work if everyone is friendly"

Participant MTA

Discussions centred around the types of conversations staff had with residents and how they greeted and addressed them in the morning and on entering rooms. Staff stated it was important to always acknowledge the resident when entering rooms and general areas where residents were gathered as this acknowledged them as human beings:

"we should all be sure to greet residents when we enter their rooms or the dayroom, I think it is very rude if staff walk in and out of these places and do not interact with any of the residents"

Participant Nurse

It was identified that this could be as simple as saying hello and checking if everything was ok or if residents required any assistance. By acknowledging the resident in this way staff were taking account of the narrative being of the resident, by providing the opportunity for meaningful conversations to occur and were also incorporating communication from the narrative aspects of care pillar:

"it is important to say hello first thing in the morning, it helps to gauge the mood for the day"

Participant HCA



Shine a light on the person's life

This theme related to looking at the past life history of the resident and utilising that information to plan effective person-centred care. When looking at residents' life currently staff were unaware of certain aspects of their past life history. They related this to the operational elements of the FNP and in particular to narrative being and narrative knowing. They believed if they had an in depth knowledge of residents' past life they could plan and organise care in a more personal way. This

theme was expressed in terms of taking account of the past life status of the resident, who they were, where they came from, but also ensuring their present life status and experience were acknowledged in their care. 'Shining a light' on the real person, where they came from and who they were in life was important for staff to be aware of as it helped with developing relationships and also with how the care the resident received was planned:

"Shining a light on the life history of the resident will help us when trying to get to know the resident and when developing care plans"

Participant Nurse



This could highlight areas of expertise or areas of interest amongst the residents that hitherto had been unknown to the staff. Shining a light would help with the way residents interacted and communicated on the unit as residents with similar interests could be facilitated to engage with one another promoting meaningful interaction:

"it's amazing sometimes the things you find out when you actually know the person, people have led very interesting lives and have done so many things we are not always aware of "

Participant Nurse

Down a hole

The theme 'down a hole' focused on the loneliness and loss that some residents experience when admitted to care and closely aligned with the narrative aspects of care in the FNP. Looking at the way residents were admitted to the unit prompted some staff to identify how this could be a trying time for some residents, and also how some residents experienced a sense of loss and grief on admission. This

sense of loss could oftentimes lead to depression or melancholy for these residents. This could lead residents to experience problems with sadness, physical contact, sexuality and privacy and this was not always dealt with by staff:

"We don't always deal with or acknowledge the loss that some people feel when they come into care very well."

Participant HCA

Acknowledging and giving residents time and space to express this loss was identified as important. However, staff also recognized that residents were not always willing or eager to share this information and that often this only came to light during an activity or when assisting with care. This highlighted, for staff, the need to use every opportunity as a way of engaging with the resident and also the importance of enabling residents to share this information:

" Its important to give residents a chance to give you information in the way they want to give it, not to push for this all at once but to maybe gather it over time."

Participant CNM

Summary

On unit 1 the staff worked with both the data they had collected and their concept of the work-place culture as identified on the work-based learning days to help them identify key themes related to narrative aspects of care. This identification of themes promoted discussion and critical reflection amongst the staff that led to the identification of strategies that they could implement in an effort to improve the way care was happening in their unit. This will be discussed in the section on developing narrative ways of working p.157.

Case Study Unit 2.

On this unit the staff looked at the data they had collected from the interviews with residents and the observations they had carried out to help them identify the present culture. Similarly, to unit 1, on work-based learning days they related the data back to the framework of narrative practice and identified 8 key themes that they felt identified the culture and that were related to narrative practice.

Table 13 Narrative Aspects of Care Key Themes Unit 2

What do narrative aspects of care mean to me?	How can this be achieved in practice?
Time to talk. can be related to doing things in a task orientated way There is no excuse for this Talking should be part of everyday activity	Talk to the resident when doing personal care or when cleaning their room or areas where they are sitting, when assisting with meals or drinks Ensuring resident is responding and is interested. Speak to residents like they are adults and acknowledge individuality Talk to residents about things that are of interest to them. Don't assume they want to know about your life, only discuss your life and interests if the resident indicates they are interested too
Attending to residents needs Resident fear that you will not return Not knowing the residents pattern or preferences	More staff would help this may not always be possible Allocate one staff member to answer bells Answer bells promptly Give residents realistic expectations and follow through with promises Identify the preferences of the resident and work with these
Environment The way people perceive the unit is also the way they perceive the care If the place is shabby then residents and relatives will think we don't care Bright light places help to promote a nice atmosphere	Liaise with maintenance to ensure that all repairs are carried out promptly Ensure that residents are consulted and involved in decisions about unit décor decision
Staff Pressures Can be a risk for residents Can cause burnout and attrition. Makes it difficult to provide good care Impacts on other aspects of care	Ensure management are aware of risks Provide a safe place for staff to discuss concerns Find out ideas of residents about how they feel about this
Knowing the resident Can help when there are issues with residents Can enable better care Will promote better relationships between staff and residents Can help to identify triggers that cause anxiety or aggression	Ensure that the resident's life history is complete Identify triggers from past life experiences that have caused problems for the resident Involve others who know the resident well if appropriate
Respect and responsibility Everyone who works or lives in the unit deserves to have respect The environment is everyone's responsibility	Ensure that everyone is treated with respect It is important that people do not see things as certain peoples jobs and leave them until that person is on duty. Staff should all help out where they can
Privacy All residents have a right to privacy Staff do not always ask permission when entering rooms or going behind curtains	Ensure that all staff are aware of the residents right to privacy Develop strategies that help to promote privacy Knocking on doors and ask permission before entering rooms or going behind curtains
Noisy Atmosphere Residents have different tolerance to noise levels	Be aware of external noises such as T.V. and radio etc Look at strategies to help the hard of hearing that do not impact on all other residents Be mindful of the effect of noise on residents

These themes were: Time to talk, Attending to residents needs, Environment , Staff pressures, Knowing the resident, Respect and responsibility, Privacy, Noisy

atmosphere.

Time to talk

Time to talk focused on meaningful conversations and ways of engaging with the residents on a daily basis. When identifying the present culture staff felt that while there were lots of opportunities for staff to engage in conversations with the residents this did not always occur. Staff believed there was no excuse to not engage in these opportunities and that time should not be a factor in preventing staff from taking the time to talk with the residents. This was associated with the care processes from the narrative framework and with narrative being from the operational elements:

"we are often too busy doing things and forget to have a proper conversation with the resident, we need to be aware of this"

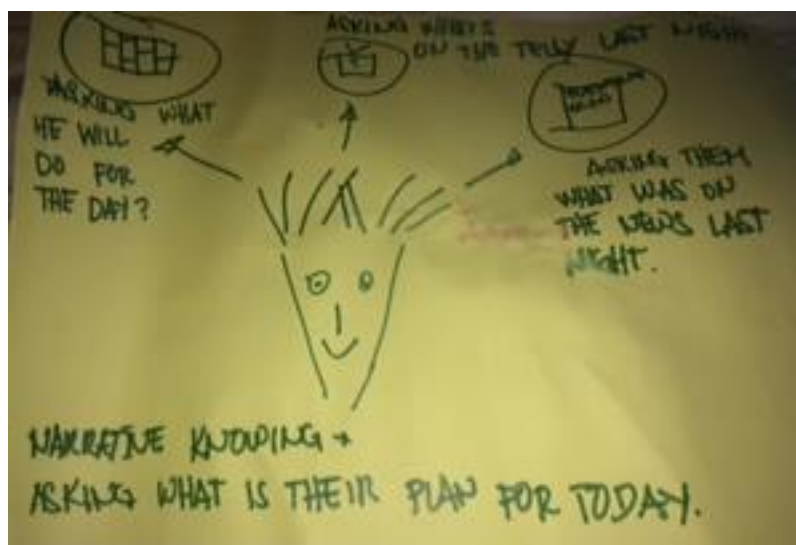
Participant HCA

It was identified that there were several occasions throughout the day where there were opportunities to engage in conversation with the residents. Meaningful conversations could take place when doing personal care or when cleaning rooms or areas where residents were sitting, when assisting with meals or drinks. It was important to ensure that the resident was responding and was interested in this engagement:

"Speak to residents like they are adults and acknowledge their individuality"

"Talk to residents about things that are of interest to them".

Participant HCA



Staff also discussed whether it was appropriate to discuss personal interests or life issues with residents. While some residents may be interested in these discussions, staff expressed an awareness of the importance of ensuring the resident wanted to be involved in these types of conversations. It was important to acknowledge that residents may not be interested in the life of the staff, and that they should check if residents were interested in discussing staff life stories, before embarking on a shared conversation:

“ Don’t assume they want to know about your life, only discuss your life and interests if the resident indicates they are interested too. “

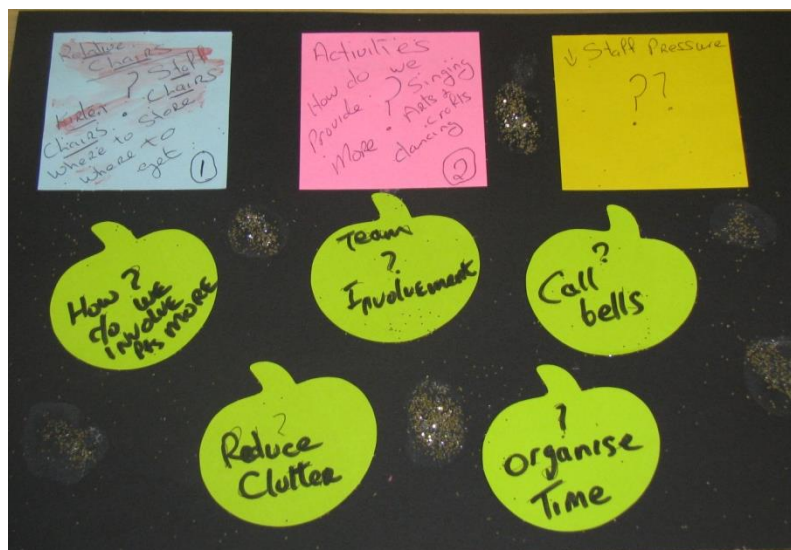
Participant Nurse.

Attending to residents' needs

The theme attending to residents' needs centred around practices that staff felt were causing anxiety for the residents. They aligned this to narrative being and to the care processes in the FNP. In the creative expressions staff highlighted several areas where improvement could take place:

“We always think we look after the residents very well but there are times when we don’t get this right”

Participant CNM



They were conscious that they did not always answer call bells, or attend to residents in a timely manner, and that this caused anxiety for some of the residents. Developing strategies to address this was seen as important. Some staff considered having more available staff helpful and that allocating one person to answer call bells may also be a good strategy. However, all staff recognised that in

order to be person-centred in their practice they needed to identify why residents were ringing, and what was the cause of the anxiety:

“Answer bell promptly but if occupied with another resident ensure the resident knows you will be back when you can, don’t specify a time as not returning within the timeframe causes anxiety.”

Participant Nurse.

Reasons why some residents felt the need to continually ring the call bell were explored with staff identifying anxiety as a possible cause of this. They acknowledged the importance of this but also spoke about the need of ensuring that the resident was aware that they had to attend to other residents as well:

“If a particular resident is ringing the bell early in the morning attend to their needs first but ensure you tell them you now have to attend to the other residents needs and you will check on them when you are free. Be sure to check on them occasionally.”

Participant Nurse.

Engaging in a more proactive way with the resident was seen as a mechanism of identifying what was causing the anxiety.

Environment

The environment as a theme related to the physical look of the unit and the feelings it evoked in those who lived, visited and worked there. In looking at the present culture and in the way it was perceived by those who lived in and visited the unit staff felt first impressions were often lasting ones. Environment and environmental aspects adhered closely to the care processes and narrative aspects of care pillars and to narrative doing from the operational elements of the Framework of Narrative Practice. The way the environment looked reflected the way people coming into and living in there saw the way care took place in the ward:

“if the ward looks shabby that gives a bad impression to the residents and people visiting, they may think we are also sloppy in the way we provide care”

Participant HCA

Walls and doors that were in need of repair reflected badly on staff and showed a lack of care and consideration. Staff stated this could impact on the way residents felt about the care they were receiving and may affect the narrative being of the person by not providing care that centred around what was important to them.



Ensuring residents should be involved in choosing paint colours, pictures and in the general decorating decisions in the unit, as this was ultimately their home, would adhere to the narrative aspects of care pillar and the operational elements of the framework. However, data collected from interviews with the residents revealed that the residents did not place as much importance on this as the staff did:

"I don't think anything could be done to improve this place there is a lovely corridor out there for walking up and down. I can't find fault with them."
Interview resident A J2T1

Discussing this at a WBL session it was acknowledged that this warranted further discussion and exploration with the residents:

"Wonder why they didn't have any ideas for improvement? Maybe they were afraid to say. Maybe they need us to help them to work out what they want. We have involved the residents in the improvements such as picking the colour of paint and where we should hang pictures etc. Maybe they already feel they are involved."

Participant CNM

Staff were surprised that the residents did not wish to engage in providing ideas for improvement to the unit and wondered if this was because they required more encouragement to participate or because they felt already involved. This unit had previously made some improvements and had engaged with the residents when making these changes. They agreed to look at this when formulating their action plans.

Staff shortages, staff turnover, the use of agency staff and the impact this had on the residents was the focus of this theme. Staff felt it was not possible for care to be centred on the narrative knowing of the resident if staff were constantly changing. In looking at the data collected staff recognised that there were times when staff shortages and use of agency staff impacted on the care the residents received and this in turn impacted on the working life of the staff themselves as they often felt under pressure:

Participant Nurse



"Maybe new staff could have at least a morning induction on the unit... I know this is not always possible with agency staff but maybe if the CNM or charge nurse had a brief discussion with them at the beginning of the shift and if we had a folder of essential information they could access during the day this would help"

Staff also discussed how they could bring what they perceived as risk to the attention of management, as they felt this put pressure on staff and compromised care. However, when staff discussed this with residents, the residents stated they felt safe:

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Staff were surprised that this was the feeling of the residents and felt it warranted further exploration:

“Glad that residents feel this is a safe place.”

“Do all residents feel this way? Something we may need to find out?”

Participant MTA.

This theme was linked with both 'time to talk' and '"attending to residents needs themes', as staff shortages affected the way residents experienced both of these themes too. Staff pressures also affected the way person-centred care was carried out in the unit.

Knowing the Resident

Knowing the resident theme highlighted the importance of knowing the past life history of residents in order to respond to needs identified or issues as they arose. This theme emerged from the creative expressions, where staff highlighted a particular issue with one resident, who was constantly shouting, this impacted on the quality of life of the other residents in a negative way. Staff related this to both narrative aspects of care and narrative knowing. :

“if one resident is disruptive it can be distressing for other residents”

Participant HCA

Having an awareness of triggers that caused this shouting could help alleviate it. It was acknowledged that having a priori knowledge of the resident and their past life history would enable staff use distraction techniques or music to help improve this situation:

“knowing more about the resident can help with identifying ways to prevent the shouting, if we know what things she liked in the past we could try some of these to distract her”

Participant Nurse

Involving the residents' visitors in identifying strategies that work and in helping to occupy or distract the resident were identified as helpful techniques and would address the narrative being of this particular resident. Taking a proactive approach to this problem and being on the look-out for things that worked would impact the

general quality of life for all other residents:

"it would be good to identify things that work to prevent shouting, I've noticed that sometimes she likes the sound of the ring toss"

Participant MTA.



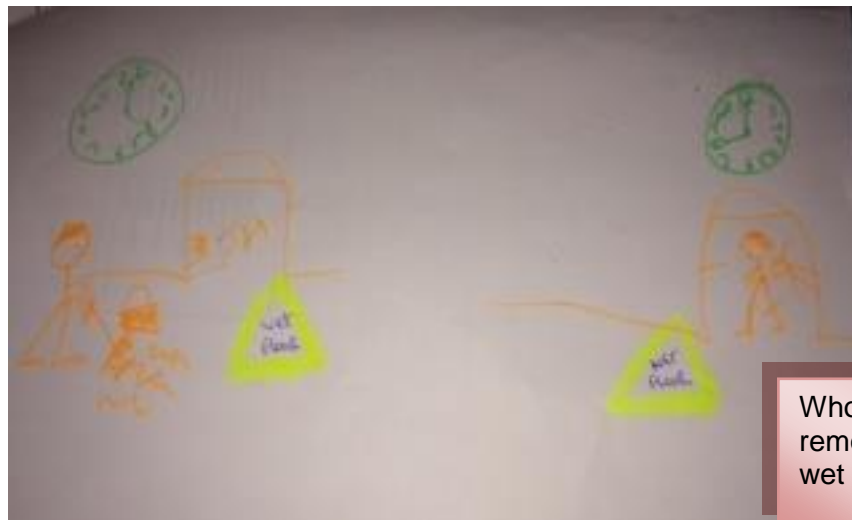
Respect and responsibility

This theme related to both the respect staff had for one another and how this affected the respect they showed to residents and also the issue of staff responsibility. This theme was very much linked to staff pressures and the environment. Staff expressed the theme in terms of caring for the environment, but also being respectful to all staff who worked there. Looking at the creative expressions of the present culture led staff to identify that the environment was everyone's responsibility and that caring for the environment showed that staff cared about all who worked and lived there:

"caring for the environment shows respect and is not just one person's job we are all responsible...."

Participant HCA

The theme centred around a statement that was attached to a pictorial representation of the present culture that was created by a participant on the first day of the programme. "Who should remove the wet floor sign?" The cleaner who worked on the unit would sometimes have to leave a wet sign up when he left work as the floor was still wet. He would return to work the next day and the sign would be still up.



This reflection led to a discussion about who was responsible for the environment and what this meant for both the staff and the residents on the unit. Staff related this to the environmental constraints section of the narrative aspects of care, and described how environment, and environmental constraints could impact on both the working life of staff and the quality of care the residents received:

“The environment should be everyone’s responsibility. Everyone needs to be aware that sometimes when the cleaner leaves the floor is still wet so the sign has to stay up but should be removed by any other member of staff when the floor is dry it should not be still there when he returns in the morning.”

Participant MTA.

Staff acknowledged that ignoring the wet signs and leaving them up until the cleaner returned showed a lack of respect, not only for the environment, but also for their co-worker. They linked this to staff attitudes, environmental constraints and effective staff relationships from the narrative aspects of care and care environment pillars of the FNP and to knowing what safety is from the narrative being operational element. They further accepted their treatment of the environment could be perceived, by residents and families, as reflective of the way they provided care for the residents. If they were sloppy, untidy and did not value the environment, it could be construed that they did not value the residents and that care was second rate.

Privacy

The theme privacy was based on staffs conceptualisation of the privacy of residents and the way this could be invaded or not acknowledged during care practices. Staff

recognized that sometimes residents' privacy was invaded by staff entering rooms or going behind curtains when care was taking place without first asking permission. Acknowledging privacy was closely aligned to narrative being and was important if residents were to feel valued. It was highlighted that they were not always aware when care was occurring with one resident in a room:

"it is not always possible to know if care is occurring in a room before you walk in"

Participant Nurse

While all the rooms had presence lights in place, when staff looked at the present culture they acknowledged they did not use them when attending to care and there was no process in place to ensure that all staff were aware that if the light was on they should not enter:

"set up some staff training regarding use of the presence lights, how and when to use them and what it means when they are on so that all staff know not to enter rooms when the light is on"

Participant MTA

They also stated that this was an issue with the bathroom that faced onto the corridor as people often walked in when a resident was being showered. Acknowledging these issues and looking at ways to improve them would ensure they were recognizing and taking account of the narrative being of the resident. Strategies such as ensuring that curtains and doors were closed, putting up a sign if attending to care, and ensuring the green occupied presence light was turned on and turned off when finished in that room were discussed:

"Put up please knock before entering signs or ensure all staff are aware they should knock on the door prior to entering the room could help improve this."

Participant Nurse.

Noisy atmosphere

This theme focused on the level of routine noise that occurred within the unit and the impact this had on residents' daily lives. Noise affected the quality of life of the residents and staff linked this to the care processes pillar of the framework and being mindful of providing holistic care and good communication from the narrative aspects of care pillar. They had previously identified a resident who was shouting was impacting on the quality of care for other resident. They addressed this in the theme knowing the resident, however, the theme noisy atmosphere specifically

related to the daily noise within the care environment. It was reported that the level of noise at times made it difficult to interact with the residents and that some residents found it difficult if T.V.s or radios were loud to accommodate the hard of hearing. Staff were aware that the amount of noise they themselves made could, at times, impact on the environment for the residents:

".....televisions are too loud because the resident is hard of hearing if this is impacting on other residents in the room investigate the possibility of getting wireless headphones. Also be mindful of the amount of noise we make, keep our voices low and avoid shouting".

Participant HCA.



However, they were also aware that at certain times during the day the noise due to tasks such as vacuuming was beyond their control. They suggested observing the residents to see how the noise was affecting them during this time and to take them to a quieter area if they wished to go:

"If noise is impacting on a resident, move them out of the area where noise is occurring if possible, if not ask person making the noise to come back at a later time".

Participant Nurse

It was important to ensure that the cleaners were also aware that tasks they were performing could have an impact on the well-being of residents and that they needed to be watchful for this.

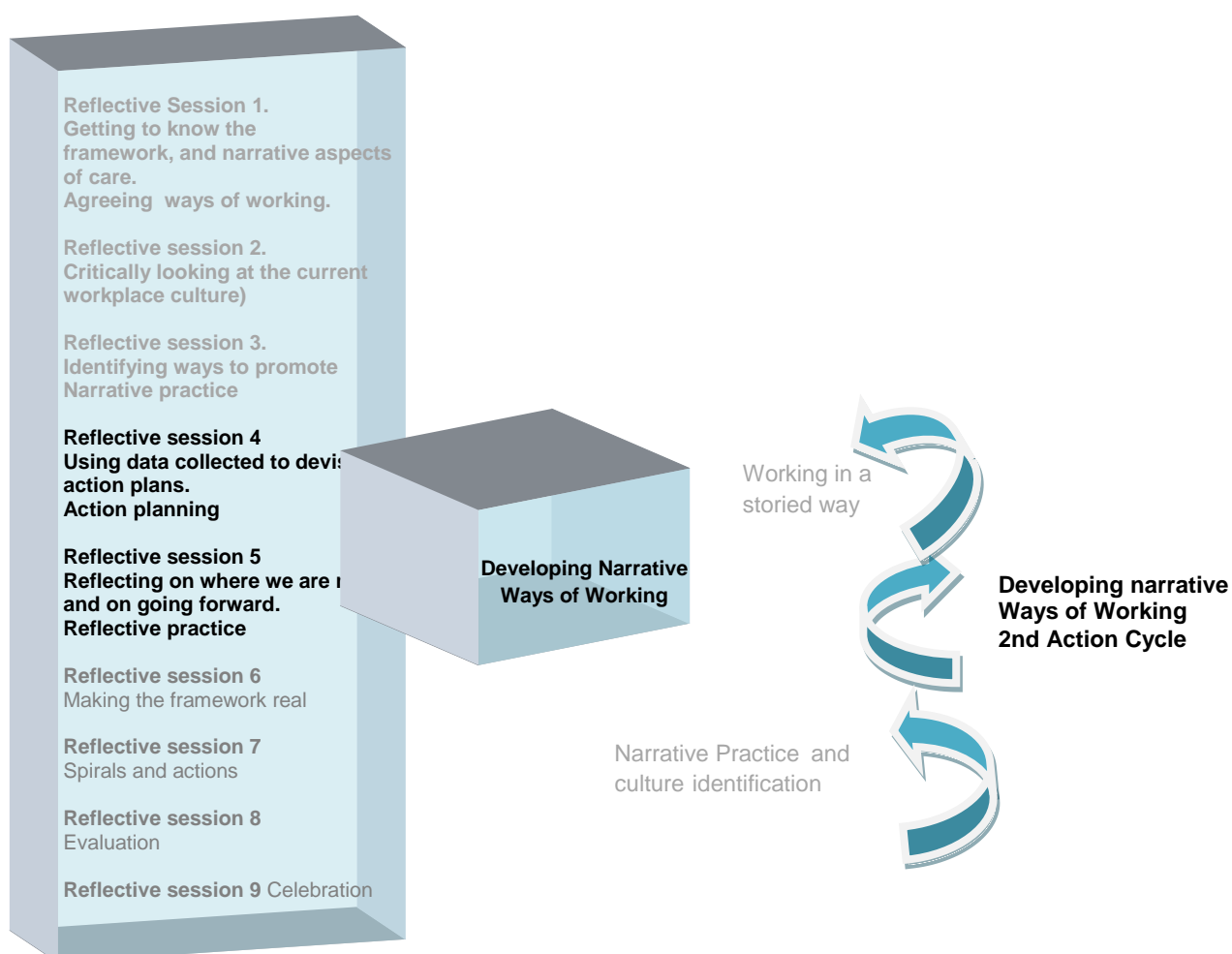
Summary.

Similar to Unit 1, Unit 2 worked with the data collected and used it to identify the way care was currently happening on their unit. They also looked at identifying strategies to implement in practice in an effort to address identified shortcomings.

Both units engaged in different ways in identifying their present culture. There were some similarities between the units but it was clear that the culture on both units was very distinct and particular to them. The process of identifying the culture enabled staff to be aware of issues they had not previously considered, have discussions about this and formulate ideas for improving and changing the culture of care.

Developing Narrative Ways of Working

Table 14 Developing Narrative Ways of Working



Having identified what the present culture looked like in both units, staff next looked at developing strategies to use in the 2nd action cycle, developing narrative ways of working. Table 14 outlines the particular work-based learning reflective sessions that were involved in this action cycle and the outcome of developing narrative ways of working that related to them. During the work-based reflective learning sessions 4 and 5, staff discussed the themes identified and critically examined them. They devised ways of using these themes, to inform improvements in the way care was carried out, and in the quality of the lived experience for the residents. The strategies and the critical thinking that informed them will be discussed below in the case studies of each unit.

Case study Unit 1.

Working with the ten themes, communication, time, non task orientated, giving comfort, privacy and confidentiality, commitment, providing for residents' needs, acknowledging the resident, shine a light on the person's life and down a hole, along with information gathered from interviews and observations of practice staff identified specific areas where a narrative approach to care could improve practice. The following four areas **communication, changing mindsets, spending time and meaningful activities**, emerged where staff could see that improvement was needed, and also as areas where they could develop actions using the Framework of Narrative Practice. They discussed strategies that would address these improvements and related these discussions back to the subthemes identified in the narrative practice and culture identification action cycle. (Table: 15) .

Table 15 Themes Strategies and Related Subthemes Unit 1

Areas of practice identified	Strategies discussed	Related to the subthemes from narrative practice and culture identification action cycle
Communication	Taking time to listen properly and not to be rushing. Set time aside (does that become a task?) Negotiate with residents/staff/family/relatives Group work – workshops bolster training of staff Appropriate and meaningful communication	Communication Non task orientated Privacy and confidentiality Acknowledging the resident shine a light down a hole

Changing Mindsets	Ensuring that people know that it is ok to set aside the tasks in favour of doing something meaningful Offer staff reassurance and education	Non task orientated giving comfort commitment
Spending time	Looking at what people are doing Make giving the residents what they want a priority	Time Non task orientated providing for residents' needs
Meaningful activity	Ensure what the resident tells you is recorded If a discussion highlights relevant and useful information ensure this is captured in the care plan Also observing residents interaction with activities that occur on the ward can provide valuable information about how they like or dislike a particular activity	Communication commitment providing for residents needs Shine a light

Staff discussed ways that these four areas of practice could be used to improve care and quality of life for the residents. They looked at areas such as how they interacted with the relatives and families, in giving and receiving information, and how this information was recorded. Ensuring that regular meetings were held with all of the above stakeholders would ensure that good practices identified in the WCCATs and observations of care were maintained. It would also help with developing strategies to improve some of the poor practices identified. Staff initiated both formal and informal ward meetings and encouraged all staff to attend. They also engaged with the relatives, and residents were encouraged and facilitated to take part in resident forum meetings. Meetings were seen as a way of maintaining the ongoing good and open **communication**, and also as a way of informing others (staff, residents, and relatives) of ongoing initiatives, and getting their ideas and support. Staff also felt that keeping narrative practice as an agenda item on their formal ward meetings would highlight to all staff the importance of this. They used the information gathered at these meetings to identify areas of practice to develop. It was also agreed that informal meetings between the staff, residents and families would be a good way of keeping everyone up to date and be inclusive. It was recognised that this would open a dialogue that may help lead to meaningful conversations with the residents. This was seen as a forum where staff could learn some more information about the life history of the resident.

Highlighting the framework of narrative practice was also a concern for the staff, ensuring everyone was aware of the framework and its intent would help with **changing mindsets** and also with ensuring **meaningful activities** were occurring

with the residents. Staff discussed ways that narrative practice and person-centredness could be highlighted to other members of staff. There was some discussion about CNMs monitoring this but the general consensus was that this would be seen as punitive and therefore counterproductive. It was considered that if staff role modelled person-centred care/narrative practice and gently reminded other staff, that this was the way we had agreed to work, that this would be a better and more constructive way of ensuring it became part of everyone's practice:

"I think if someone just said to me, you know, we agreed at the last staff meeting that we would do such and such like this – maybe you hadn't known that- but the reason we are doing it this way is...." "Well I think I would be more likely to listen and do it that way than if someone said well I can't believe you did that, it's totally wrong what were you thinking". "I think the way an approach is made, can make you feel small and not valued, we work hard we need to feel appreciated".

Participant Nurse

Discussion also took place around the importance of ensuring that nursing documentation reflects both the activities and hobbies the resident took part in prior to admission, and any relevant discussions that occurred with the resident that may help to inform their care. Linked with this, observing residents' interaction with activities could provide valuable information about how they liked or disliked a particular activity:

" Ensure what the resident tells you is recorded. If a discussion highlights relevant and useful information ensure this is captured in the careplan".

Participant Nurse

Spending time focused on the time spent with residents and also the time staff spent on tasks. Ways of working and how the structure of the day was managed were areas identified by staff as needing improvement. Spending time needed to be based on the priority of the resident, for how they would like to spend their day, and not be dictated by tasks that staff felt should be completed. This also opened a discussion around education for staff regarding how they should accomplish this. Short reflective sessions were identified as helpful in identifying strategies to employ that were both beneficial to the residents and that also helped staff work effectively. Techniques learned from sessions and person centred practice ways of working helped them to effectively plan care that was resident focused and directed. Staff stated they felt empowered by knowing and being able to use these techniques effectively.

Unfortunately at this point in the project several factors impacted on the ability of the unit to engage fully in the project. Namely these were severe staff shortages, reconfiguration with derogation of staff, and a bi-annual rotation of staff.

Because of these factors when I attend the unit for their 4th WBL session there appeared to be a totally different complement of staff in attendance than had been at the previous sessions. As a workplace learning activity and a way of gaining an insight into the way residents would like care to occur, staff had committed to undertake interviews with residents prior to this session. I was both disappointed and worried that this had not been carried out:

"I was surprised to see that there appears to be a totally different staff compliment here from my last visit.... Wondering how this will impact the implementation."

Researcher's field notes WBL 4

Staff, however, stated they had informal interaction with the residents and asked some of the interview questions but had not recorded this in a formal way. We negotiated that we would work with the strategies identified on the day 3 WBL session and formulate action plans from this information. After looking through, and discussing the strategies the staff identified communication as a major emerging theme. Staff felt that working with the **communication** strand could encompass some of the elements of the other three strands, previously identified, and could be an overarching action. Because the aim of the study was to be inclusive and participative and the staff had expressed concern but still wanted to continue with the project we agreed that working in this way would enable them to do that. However, they did recognise that an overarching action of communication could lead to smaller spirals of action occurring within the bigger communication picture.

Initially staff had identified four areas of practice they would like to focus on: **communication, spending time, changing mindsets and meaningful activities**, however, due to the constraints they were now reluctant to take on too much and after discussions during the work-based learning group session decided to focus on only one of these actions. They agreed to work with this as an action plan (Appendix 15) and focused on communication between staff/staff, staff/residents and staff/family/friends. Areas where staff felt communication could be improved were;

life story work, informal discussions and how this was documented or recorded in the residents care plan, the interactions staff had and supports needed to maintain and implement good/ effective communication.

Case Study Unit 2.

On unit 2 the staff critically reflected on the themes they had identified in the culture identification phase of the action: Time to talk, Attending to residents' needs, Environment, Staff pressures, Knowing the resident, Respect and responsibility , Privacy, Noisy atmosphere. They identified areas of practice from using data collected from observations of practice and interviews with residents, that could be addressed in a narrative way taking into account issues identified in the themes. Three areas of practice were identified as areas that staff felt they could improve. These were **homely environment**, **having more going on with/for the resident** and **intercommunication**. As the staff addressed these themes, at informal ward meetings between their scheduled work-based learning days, a further theme emerged from data collected, this was the theme of **meals and mealtimes**. Staff agreed to add this to the previously identified themes and to work on these four areas of practice. Similar to case study 1, the staff on this unit related these discussions back to the subthemes identified in the narrative practice and culture identification action cycle (Table 16).

Table 16 Themes Strategies and Related Subthemes Unit 2

Areas of practice identified	Strategies discussed	Related to the subthemes
Homely environment	Ensure that residents are consulted about improvements to ward Try to minimise clinical equipment and signage in common areas and rooms Continue with personalisation around bed spaces Ensure privacy and dignity are maintained as they would be at home	Attending to residents' needs Privacy Environment Knowing the resident Respect and responsibility noisy atmosphere
Having more going on with/for the resident	Ensure that there are meaningful activities taking place ie. reminiscence art outings etc. Ensure the residents have appropriate implements such as glasses with them so they can fully take part Set aside time for someone to sit with the residents to help if activity going on so they can join in.	Time to talk Knowing the resident
Intercommunication	Maintain the good communication that is currently happening Ensure the communication is	Time to talk Knowing the resident Privacy

	appropriate, takes account of time, place and mood of the resident and if joking that it is welcomed and reciprocated Intercommunication between all staff grades, residents, and families – initiate informal and formal meetings to address this Good listening skills promote and increase good communication	Staff pressures
Meals and mealtimes	Ensure that meals and mealtimes are prioritized and that all other activity is stopped so that all staff can assist residents Look at ways of improving the dining experience for the resident Link with kitchen to ensure meals are correct temperature and the resident gets what they want	Attending to residents' needs Environment.

Over several programme days, staff discussed and worked on ways of developing actions around these four themes. Further strategies were identified, that could be implemented to improve quality and the experience of the resident. Ensuring that the unit had a **homely environment** and that it was recognised as residents' home, was an ongoing issue. Staff felt this impacted on the way the unit was perceived within the hospital and by those visiting and living there. The welfare and happiness of the residents came first and sometimes it was necessary to break the rules to ensure the resident was happy. Further engagement occurred with residents to identify if the residents felt having a homely environment was important. Staff wanted to identify why residents did not place as much importance on being part of the improvements on the unit as the staff did. Residents stated a homely environment was very important to them but that they already felt included in discussions as their opinions had been sought when previous improvements were being made. Discussions included challenging regulations and how that could be achieved. Staff felt that sometimes it was better to beg forgiveness than to ask permission. Focusing on ensuring the unit was as homely as possible would ensure that care was centred on what was important to the resident (knowing the resident), and also would link with the privacy theme identified in the cultural identification exercises. Staff stated that areas around residents' bed space could be personalised with either pictures or artwork. They also felt that the family room could be decorated to provide a quiet private space for residents and visitors to meet. Staff engaged with the residents and critically looked at the current environment. With input from the residents they jointly identified ways of improving residents' personal space. Staff further identified getting the opinions of residents

when decorating or changing the day room as a means of ensuring respect and responsibility for all who lived and worked in the unit. Knowing the resident linked to the themes noisy atmosphere and attending to residents' needs. Staff highlighted that in-depth knowledge of residents' likes and dislikes could lead to a quieter atmosphere as this helped staff anticipate residents' needs. Staff and residents identified this as positive as it helped to create a sense of peace and calm.

During the identification of the ward culture exercise, staff and residents acknowledged that there were not enough meaningful activities happening on the unit. Working with narrative being (paying attention to and interpreting events), and narrative knowing (perceptions, reflections and shared understandings), staff felt would help with having **more going on with/for the resident**. This could help them design meaningful activities that incorporated the past life experiences of the residents. Staff discussed ways they could ensure that the time residents were spending in the day room during the day was meaningful. Ensuring that there was a choice of activities going on throughout the day would enable residents who wanted to participate to do so. This discussion was linked to the framework of narrative practice and staff discussed how utilising the framework could assist with this. Discussion centred around both identifying the narrative being and narrative knowing of the resident. This would ensure that conversations that identified the views of the residents and what they felt was important, and elements of the resident's past lifestyle and status would be taken into account when planning activities. Using this approach staff were able to develop action plans that took account of the preferences of the residents. All interactions should be meaningful and this could be accomplished simply by taking the time to talk to the resident. Ways of talking to the resident in a meaningful way could be incorporated into everyday activities such as care episodes or when attending to cleaning duties in residents' rooms. The importance of ensuring the resident was also engaging in this exercise was discussed. Strategies such as speaking in a slow way, giving the resident time to respond and discussing issues pertinent to the resident were incorporated into action plans (Appendix 16).

The theme **intercommunication** focused on the communication that was taking place and the way staff felt communication could be improved on the unit. While this theme was similar to the theme communication as identified by unit 1 the staff

on unit 2 were insistent that it be described as intercommunication. They felt this designation accurately captured all the different types of communication and all the different interactions that occurred around communication. For them this was a more encompassing word to describe the communication that needed to take place. Staff looked at the way they communicated with the residents, families and with each other. They identified areas of the narrative framework that would help them improve and enhance the communication that took place. An area of communication that staff felt could be improved was the way residents were acknowledged when staff arrived in the morning or in the evening. Ensuring that they greeted the residents and acknowledged their presence prior to commencing their daily task, was highlighted as a way of recognizing the person-hood of the resident. It was also important for staff to ensure that the residents were orientated to date, time and local issues or events. This would ensure that residents felt involved and interested in what was going on in the unit and in the locality. Staff expressed the need to ensure they gave time to talk to the residents and that this could be achieved as part of the daily care routines. Areas such as active listening, ensuring the resident was interested in the topic and being aware of the past interests and hobbies were highlighted as ways of initiating, and maintaining, conversations with the residents.

In relation to relatives and significant others it was important to acknowledge them and who they were. Keeping them informed about ongoing activities and the residents condition (with the residents permission), enabled communication that centred around the resident and their significant others. This way of communicating enhanced the communication that occurred between the resident and their visitors, as it gave them mutual events and occasions to interact about. Staff further recognized that this type of communication could help them when identifying and attending to residents' needs.

A further area of communication identified as important was the communication that occurred between staff. This was important for good working relationships that all staff were involved in the handover as this not only showed respect for all grades but also prevented the need for nurses to relay information second hand to care assistants and cut down on the time that was spent on this unnecessary handing on of information. Staff emphasised that good respectful communication between staff

led to respectful communication with residents and relatives, and was the first area of communication that should be addressed. Being respectful and mindful of their colleagues meant being open to and encouraging of new ideas, ensuring that efforts were praised and promoting positivity and motivation. This led to a working environment that ensured that all who worked and lived there were engaged and interested. Staff believed this adhered to both the foundational and operational aspects of the framework of narrative practice. Staff stated the ability to engage with residents in this way could alleviate some of the issues highlighted with staff pressures as they would be providing care that centred on the individual in the way they wanted it provided. The staff on this unit along with the staff on the other unit were also involved in the development of the prompt sheet for narrative documentation (Appendix 19) which will be discussed in Chapter 8.

Meals and mealtimes had arisen from a team meeting initiated by the CNM 1 in between the WBL days. The theme had not occurred in any of the WBL days or learning activities previously but was an issue that staff identified from observing care and through work-based reflective practice. The theme showed that in an action research approach looking at one particular spiral of action can lead to the identification of further spirals of action (Reason & Bradbury 2008). It also highlighted the need for a flexible approach and closely adhered to one of the principles of work based learning, collaborative participation, where individuals work together to achieve a common goal.

Staff identified, from observations of care, that some residents were not getting their meals at the correct temperature and that in particular the unit had an issue with keeping hot desserts hot. They critically reflected on the way meals were currently being served. They identified strategies to enable them change the current practice to one that would ensure the maximum number of staff were available to assist residents. They also ensured that the meals were served in a way that ensured all residents were receiving hot meals. While this was not a theme identified in the identification of culture and narrative aspects of care phase it was linked with the themes of attending to residents needs and environment. Staff also closely linked this to the foundational elements of the framework and also to the operational element of narrative being (caring that is centred around what is important to the resident). Staff further identified aspects of the environment that they felt were

impacting on the mealtime experience of the residents and set out action plans to address these issues and to improve the dining experience.

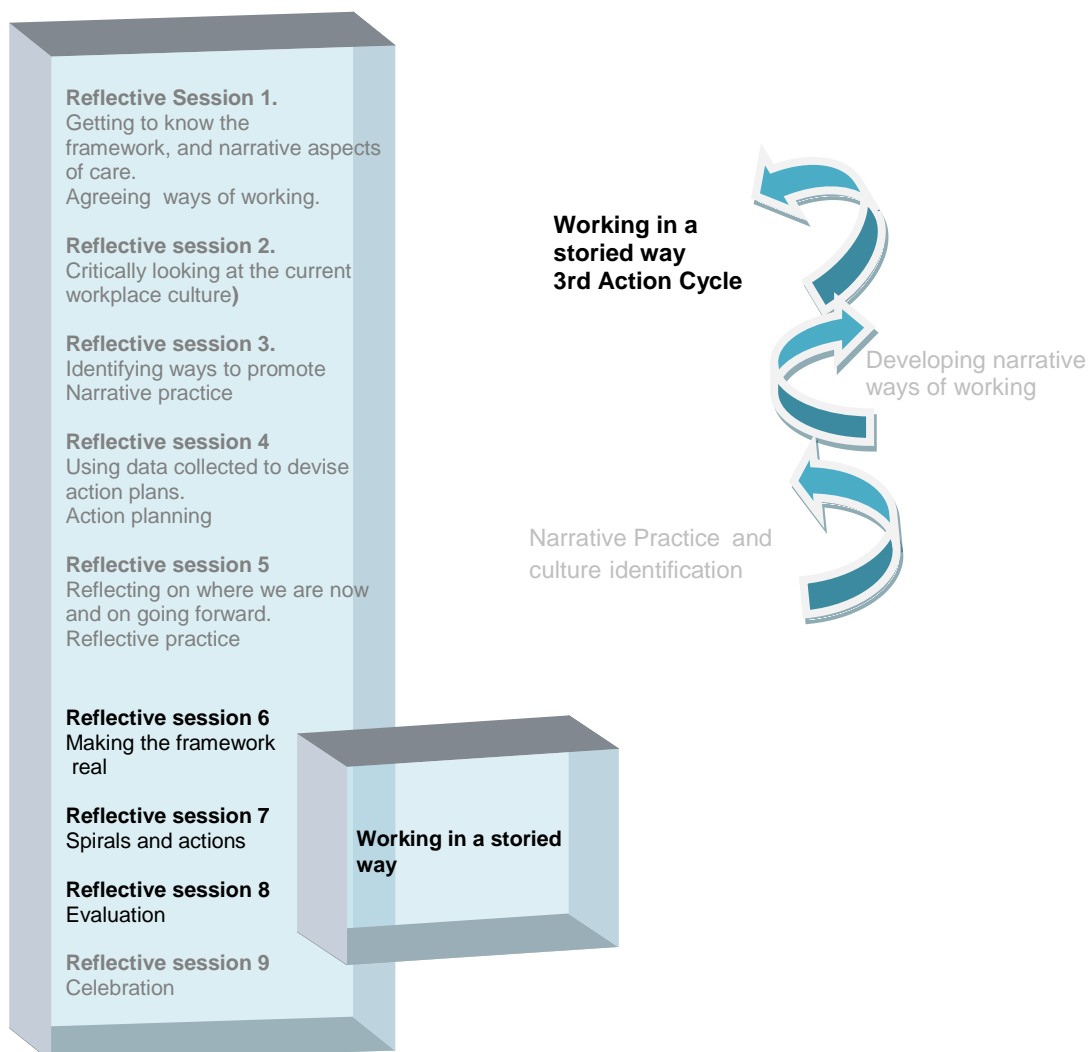
Summary.

On unit 2 staff took a proactive approach to developing narrative ways of working. They worked with the identified practice areas and critically examined the current way these areas of care were occurring. They further identified strategies that that they felt would help them with implementing changes in the practice setting.

Developing narrative ways of working on both units focused on interactions staff had and supports needed to maintain and implement good/effective narrative informed care. Staff worked with an action plan template (See Appendices 16 & 17 for examples) to outline the action plans and how they would attempt to achieve them. The way staff developed these action plans and the resultant improvements in practice will be discussed in the working in a storied way section.

Working in a Storied Way

Table 17 Working in a Storied Way



Working in a storied way action cycle was concerned with implementing the strategies and ideas identified in the developing narrative ways of working cycle in the practice setting. Table 17 above outlines the reflective work-based learning sessions that were involved in the working in a storied way action cycle. Staff used action plan templates to identify the approaches they needed to take, people they needed to engage with, and resources that were needed to address issues identified. The two units had different approaches to this implementation and this is highlighted within each case study.

Case study Unit 1

The staff used the communication action plan to develop a suite of communication tools that they felt would both improve communication between staff, particularly the temporary staff, and help improve the care experience for the residents. These included a communication handover sheet, medication communication sheet with the way residents take their medications listed, bed list with room and bed number for each resident, my day my way sheet (Appendix 18) and a laundry list regarding how residents clothes are laundered. The handover list is a very comprehensive document listing names, date of birth, if resident requires assistance with activities of daily living, mobility status, continence status, brief medical history, and any other relevant information ie needs to have fluids thickened etc. Staff acknowledged that all of this information was available in residents care plans. However, they felt that having a sheet with all this information listed, to use at handover or to give to new or agency staff, was a helpful method of ensuring continuity of care for residents. Staff used this list at change of shift to highlight any changes in condition of the residents. They also gave it to relief and agency staff to acquaint them with the residents and their particular care needs. Staff on the unit reported that it gave them peace of mind knowing residents were being looked after correctly:

"this is a good method of ensuring the safety of the resident as well as ensuring their likes and dislikes are known by new staff."

Participant CNM

Implementing these tools also helped the staff recognise that the current way they conducted handover was not effective. The handover routine was impacting on the amount of time the staff had to spend with the residents first thing in the morning when breakfast was being served and the residents needed more help. The unit was split in two and this had led to a situation where two members of the night shift were giving two separate reports to the day shift. Staff looked critically at this practice and developed an approach whereby one member of the night shift gave report to the oncoming day charge nurse. This ensured that all other staff were free to assist residents with their breakfasts and received report after breakfast was over. This change meant that staff on both sides of the unit needed to be aware of the happenings on the other side. Staff felt this led to an increased and better flow of communication between both sides of the unit, and to a better experience at breakfast time for the residents.

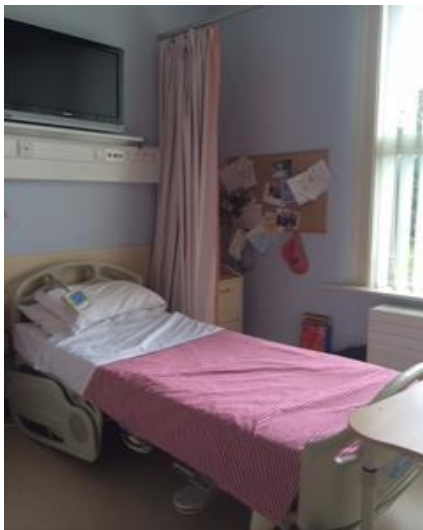
In an effort to improve communication and to make documentation practices more narrative and person-centred staff had also agreed to look at the way documentation was carried out. To help with this I, along with staff from both units, developed a documentary analysis tool. The analysis provided by this tool led to the development of a documentation prompt sheet (Appendix 19)(the analysis and development of this sheet will be discussed in greater detail in Chapter 9). On this unit staff used the sheet at the front of the resident nursing notes as a prompt to encourage documentation practices that focused on narrative and the resident experience. The implementation of the sheet helped staff identify that documentation practices were often written in a biomedical way with little or no written evidence of the feelings or thoughts of the resident. The project highlighted an increased need for good note taking and a need to have better communication with families and residents.

In a further effort to identify what residents' felt was important to them in their daily life, staff implemented My Day My Way exercise (Appendix 18). In this exercise staff gathered information from residents regarding the things that make them happy in their daily life, and the things that make them unhappy or that they did not like. This worked for some of the residents, however, some while happy to discuss with staff what made them happy did not want to have it documented in a formal way on a chart. Staff did not explore the reasons for this in any great detail with residents but reported that some residents felt this was an invasion of privacy. Staff felt this was important to be aware of and that sometime charts such as this may impinge on the privacy of residents. They negotiated with all residents whether they wished this information to be available or not. This process took time and staff were also aware that this information while valuable could and would change over time necessitating its review on an ongoing basis.

Case study Unit 2

On this unit the staff took a different approach to the WBL. They not only attended the scheduled co-facilitated WBL days, but also conducted ward meetings in between the WBL days that were facilitated by the CNM 1. On the WBL days and in meetings initiated by the CNM, the staff on this unit devised a number of action plans using the action plan template (examples Appendices 16 & 17) to address the four themes they had identified. Looking at making the unit more homely staff

elicited the input of residents and came up with several different ways to improve the physical environment. Residents stated that the unit lacked mirrors, staff negotiated with maintenance to install mirrors in the areas where a need was identified. In further efforts to promote homeliness staff encouraged family and residents to bring in their own soft furnishings or paintings from home. Staff displayed the paintings around the residents bed space and used the soft furnishing to individualise each bed. This not only adhered to the narrative aspects of care of the framework but also helped some of the residents with way finding and recognition of their own personal space.



To acknowledge the present life of the residents staff collected photos of outings and celebrations on the unit. They arranged for photographic display units to be

mounted on the walls in the corridors of the unit and displayed these photos, changing them as other outings and celebrations took place



In an effort to promote the independence of the residents, and to provide an environment where they were able to manage their own affairs, staff linked with maintenance and installed personal safes for each resident. On WBL days staff reported that this adhered to the narrative being of the resident ensuring that they were providing care that 'centred around what was important to the resident and that included privacy and dignity'.

Endeavouring to design meaningful activities for the residents, staff had conversations with residents around what type of activities they would like to take part in. They used the information gathered to supplement the ongoing activities with ones that the residents had specifically identified they wished to pursue. A wide range of ongoing activities were implemented by the staff, and both staff and residents agreed to evaluate if these activities were meeting the needs of the residents. These included:

- A movie night that took place once a month where old films were shown.
- The introduction of a portable bar where residents could obtain a drink in the evenings (staff also purchased half pint and wine glasses for a more authentic feel).

- Library newspaper holders to enable residents read the paper in comfort.
- The purchase of a Nintendo Wee, a ring toss board and other board games to promote activity for the residents.
- The creation of a memory or quiet area in the garden and installation of a decorative cross. Residents used this area to mark the passing of a deceased fellow resident.
- An outing to the Old English Market (a famous landmark in the city) and City Park.
- An art exhibition where the art work of the residents was showcased on the ward with all other wards invited to view the exhibition This event was also used as a celebration of the units involvement in the project.
- Encouraging family to celebrate special occasions such as christening, weddings and birthdays with the residents and facilitating this by providing party food and drinks for the celebrations.

An initial strategy employed by staff to address the communication theme was the implementation of life story books or memory boards for those who were unable to complete books. Family members of residents who were cognitively unable to complete the story books, were given a copy of life story guidelines and encouraged to engage in the process. Staff reported that the life story books provided information that helped them develop individualised care and activities for the residents, that centred on their past life experiences. They also felt that this was a way of increasing the communication that occurred between the relatives and the staff, and that it promoted involvement of relatives in the care of the resident.

Staff also looked at the way communication was carried out in their documentation practices. Similar to Unit 1, staff here trialled the documentation prompt sheet. On this unit staff placed the prompt sheet at the front of the patient chart, but found that most staff did not see it there. After discussion and negotiation staff felt the best place for the prompt sheet was at the back of the chart along with the other daily flow sheets. Placing it there ensured it was highly visible, and increased the chance that it would be seen when commencing documentation.

In an effort to address and improve the intercommunication that occurred between staff, the unit commenced a policy of all grades of staff being involved in the

handover report. In the team meetings that took place between the WBL days staff discussed ways of promoting better communication between staff, this included:

- Initiating a schedule of staff nights out to increase social interaction and as a way of team building and increasing team work. These nights were optional and staff could attend if they wished to do so.
- Approaches to ensure that everyone had an input into developing new ideas on the unit. This included presenting the idea at team meetings, discussing as a team and developing ways of trialling and evaluating the idea.
- Promoting positivity and motivation by acknowledging work well done, and speaking with respect to colleagues.

Staff found that while they developed separate action plans for the four identified themes there was a certain amount of overlap between the themes. In particular the **meals and mealtimes** and **homely environment** actions had some overlap. Staff purchased fine bone china cups for the residents use as a way of making the dining experience more like home, this action also addressed the meals and mealtimes action. In the observations and interviews with residents staff had identified that some residents were not getting their meals at the correct temperature. To address this issue and to ensure that all who needed help at mealtimes were getting assistance staff initiated several approaches. To address a problem with residents not getting their hot deserts hot, kitchen staff kept all hot deserts warm and delivered them after dinner with the tea. Staff also came up with the idea of dividing the unit into 2 and only gave out the meals on one side at a time so all staff could assist residents who needed assistance. Meals were commenced on the 2nd side when all residents on the first side had been assisted. Staff further implemented a protected mealtimes strategy ensuring no unnecessary procedures or ward visits/rounds were occurring while meals were in progress and all staff were involved in assisting residents. Further addressing both the meal and mealtimes and the homely environment themes staff purchased table cloths and menu boards. They ensured that the tables were set for lunchtime as they would be in the residents home.

Summary.

Overall while the staff on unit 1 engaged well with the identification of the culture and development of the action plan, the implementation of these action plans proved

problematic. Staff focused on a technical approach that placed value on using tools as a means of identifying resident experience. They did not utilise the information they collected in a critical way to change the care experience of the older adults or to challenge practice or culture. Rather they used it as simply another method of gathering and storing information that did ensure the care the residents received was safe and particular to them but that often occurred in a haphazard way depending on who was interacting with them.

By contrast on Unit 2 staff engaged in a positive and proactive way with the identification of culture, development and implementation of action plans. All staff, residents and relatives were involved in the discussions that took place around the action plans and a participative and collaborative approach was used when implementing the plans. The staff critically reflected on the current practice and used the information they had gathered to both inform change and develop strategies to help them deal with challenges identified and to improve the care experience for residents. In this way they achieved an emancipatory action approach both by increasing and developing their own knowledge and also by changing the practice setting and culture of care to ensure that the quality of life of the residents was improved.

Conclusion

The findings show that both units employed very different approaches and styles in the implementation of the action plans. It highlights that the approach taken influences the outcomes with unit 1 outcomes being tangible products such as handover sheets and documentation and unit 2 outcomes clearly evident in the improvement in quality of life for the residents and change in the culture. Unit 2 used a more inclusive approach and a willingness to engage with all stakeholders in a participatory way, ensured that the action plans developed were resident and staff led and informed changes in practice that improved the care experience for the residents. The project was evaluated at two time periods throughout its life, once mid project and again at the conclusion. While evaluation was ongoing and part of the action research process, occurring as part of the WBL days, this specific evaluation was an overarching evaluation designed to evaluate the ongoing culture change and unit engagement. This evaluation further highlights the differences between the two units and will be discussed in chapter 8.

Chapter 8 Evaluation

Introduction

Evaluation in action research is a way of looking at the project as it is going along and also a way of assessing the benefit of the project when it is complete (McCormack & Buckley 2014). It is an integral part of action research, throughout an action research project judgements are made based on actions taken, and their effect on the culture or environment (Heron & Reason 2008). The way that evaluation occurs in participatory action research is not predetermined, but reflects the approaches taken in implementing the practice change (McNiff 2000). In this study evaluation was both ongoing, happening at each WBL days, and summative. The ongoing evaluation informed minor changes, or approaches, to overcome challenges that were seen during the implementation of the framework of narrative practice. The overarching evaluation was used to assess the effectiveness of the implementation, and also to look more globally at the challenges. Information gained from the evaluation was used at programme days with participants in a continual way of looking at the overall culture of care. Overarching evaluation of the project occurred at two time points throughout the study. Point one occurred midway through, approximately 9 months after the commencement of the WBL group sessions and point two at the end of the study, 18 months after commencement. The purpose of these evaluations was to reflect on the ongoing implementation at point one, and to look at the effectiveness of the processes being used. It also looked at the changes that were occurring in the two units and highlighted differences and similarities. At time point two the intention was to evaluate the overall effectiveness of the implementation of the framework of narrative practice. Along with the evaluation a separate documentary analysis was also undertaken. While the results of this analysis formed part of the overarching evaluation, its primary function was to assess if the documentary practices of the staff reflected the changes that were occurring in the practice settings. It was also used to ascertain if the framework of narrative practice informed the way staff undertook documentation. Lewin (1946) described action research as a sequence of steps, at whose heart is evaluation and developing knowledge from that evaluation.

I conducted this evaluation along with 2 experts. All data collected as part of the work-based learning activities, research field notes, the researchers reflections, meeting notes and minutes, and information gathered in the documentary analysis activity were used to inform the evaluation. Because the documentary analysis tool had a dual purpose, it is necessary to describe its development, and the analysis of the nursing documentation on each unit, prior to describing the overall evaluation of the study.

Documentary Analysis

Documentary analysis was a separate and unique activity that occurred at two time points throughout the study. The current documentation used person-centred care as an underpinning philosophy and Roper, Logan and Tierney's Activities of Daily living as a guiding framework. The care plan was divided into 12 sections, safe environment, mobility, skin assessment, personal care, nutrition, elimination, mental status, communication, pain, temperature breathing and circulation, social activity and spirituality. Care was documented in a narrative format within each section. The units also used an Activities Therapy Assessment (ATA) form that was completed by the Activities coordinator with each new resident shortly after admission. The intent was to use the information contained within this form along with the information gathered by nursing staff in the admission assessment to inform and develop the plan of care. The documentation pack had evolved from facilitated discussion with staff and residents, drawing on experience of working with older adults, evidence based practice and HIQA (HIQA 2007) standards.

Nursing documentation is crucial to ensuring that both accurate and precise information is available to the healthcare team caring for older adults. It contributes to overall communication and ensures continuity of care (An Bord Altranais 2000). In long term care settings, nursing documentation should provide information about the care needs of older adults, their current treatments and their engagement with the care settings (psychosocial needs) (Hooks & Roberts 2007). Studies looking at the effectiveness of nursing documentation have shown that often they were incomplete, frequently interventions were not evaluated and psychosocial aspects of care were not always assessed or evaluated (Hyde et al 2005, Hooks & Roberts 2007).

The advantage of narrative documentation is that it enables nurses explain or describe assessment or intervention in the words of the resident. It allows for an in-depth and detailed account of care episodes, and promotes the use of the person's story highlighting the experience, and experiences of the person receiving the care. In Byrne's, 2012 essay on the benefits and challenges of narrative documentation, he posits that narratives have limited usability and are difficult to audit. He privileged the use of standardised terms and flow sheets that allow for a tick box type of recording. In my experience narrative provides a richer source of information than simple tick boxes, it also allows for the words of the resident to be used when describing care episodes. As Byrne (2012 p.203) freely admits himself, this type of documentation "allows for broader clarification and expanded explanations". I would therefore challenge Byrne's assertion regarding their usability. I would further propose that narrative is no more difficult than any other form of documentation to audit. In a systematic review on quality of nursing documentation and approaches to its evaluation, Wang et al. (2011), found the key to a successful audit was to have an audit tool that interrogated the documentation with a specific narrative intent.

Design.

Bearing this in mind, and because I wanted to interrogate the current documentation to see if elements of the framework of narrative practice were being utilised in the documentation practices of the nurses, I developed a narrative analysis tool that was based on the operational elements of narrative described in the framework of narrative practice; narrative being, narrative knowing and narrative doing. The intent was twofold:

1. To investigate if nurses were documenting in a narrative way and
2. To assess if the implementation of the framework of narrative practice informed or changed the way nurses documented care.

Data, gathered from resident care plans, were analysed using content analysis (Elo & Kyngas 2008). Content analysis is structured around identifying concepts within texts or sets of texts and specifically for this analysis on the relationship of the documentation to the framework of narrative practice. The following set of questions were designed and used to critically examine the nursing documentation.

Documentary Analysis Tool.

Narrative Being

1. Is there evidence of two way (between staff/residents, residents/residents) and three way (between residents/relatives, significant others/staff) communication taking place? How is this captured? How is this communication recorded?
2. Is there evidence that the residents past and present community and family involvement is recorded? How is this captured?
3. Is there evidence that the residents views on what they think is important for a good quality of life is recorded? In what way is this captured?
4. Is there evidence that the way the resident responds to change is recorded? How is this recorded?

Narrative Knowing

5. Is there evidence that the expectations of the resident regarding what they would like from the care experience have been recorded? In what way is this recorded?
6. Is there evidence that the residents previous lifestyle is recorded? How is this recorded?
7. Is there evidence that the previous life status of the resident is recorded? In what way is this information recorded?
8. How is the residents feelings regarding the loss of their previous lifestyle, status and abilities recorded?
9. In what way has the residents decisions regarding their care been recorded?
10. How has the resident's insight into their safety limitations been recorded?
11. Is there evidence that the resident has been introduced to everyone who lives and works on the unit? In what way is this recorded?

Narrative Doing

12. Is there evidence that the hobbies, activities, and societies the resident used to take part in prior to admission are recorded? In what way is this recorded?
13. Have the resident's feelings or concerns regarding being admitted to long-term care been recorded? How is this recorded?
14. Is there evidence that the resident has been introduced to how decisions regarding the daily operation and continual improvement of the unit are recorded? In what way is this recorded?
15. Are elements of narrative being and narrative knowing captured in a narrative doing way in the care-plan?

These questions were developed by taking account of the three operational elements of narrative in the framework of narrative practice. The elements of narrative being, knowing and doing were explored to discover how they would look in nursing documentation. This critical investigation outlined where each element was likely to be accounted for and how it would be described in the current nursing documentation used on both units. (Table 18)

Table 18 Exploration of Narrative in Nursing Documentation

Element of narrative	Description	How does the Narrative analysis tool account for this.
Narrative Being	<p>Is about paying attention to events taking account of what happened in the past, what is happening now and what might happen in the future. Interrogating our existence helps us to understand the meaning of our being and locate us in our present reality.</p> <p>Narrative identity describes being as the way in which we respond to change and act with others in a period of time.</p> <p>Focuses on types of communication, what is important to the resident and their views on organisation of care including privacy and dignity.</p>	<p>Resident past and present community and family involvement are recorded.</p> <p>Captured by asking the resident what they think is important for a good quality of life and also by enquiring if the way that residents respond to change is taken account of.</p> <p>Captured by enquiring if the views of the resident on what is important to them is recorded including privacy and dignity.</p> <p>By enquiring if all communication between resident/staff/relatives/significant others is recorded and taken account of.</p>
Narrative Knowing.	<p>Not only about life story but also about perception, recognition, reflections and shared understanding.</p> <p>Focuses on context and is based on situating the person in time and place. Acknowledging their selfhood. NK is about ensuring the identity of the I that is rooted in the past is accounted for in the present time and is allowed to shape the future story.</p> <p>In acknowledging NK the nurse/carer must ensure the I is protected but must enable the resident cultivate a new</p>	<p>Related to finding out desired expectations of care in Narrative analysis tool.</p> <p>Interrogates the documents to see if the residents feelings regarding loss of previous lifestyle, abilities, and status are recorded.</p> <p>Enquires if the residents decisions regarding care are recorded.</p> <p>Enquires if the residents views on safety are recorded.</p> <p>Enquires if the resident is</p>

	<p>story one that includes their present living arrangements. Chinn and Krammer identify ways of knowing as “ways of perceiving and understanding” then narrative knowing is a way of perceiving and understanding the story of the individual taking account of salient aspects of their present history but at the same time ensuring their past life status is also acknowledged.</p>	<p>introduced to other residents and staff and the residents forum.</p> <p>Enquires if the residents views on being admitted to long-term care are recorded including loss of independence and having to rely on others.</p>
Narrative Doing	<p>Relates to intentional action. Narrative doing is about ensuring all activity is meaningful, has a purpose and provides an outcome for the participants.</p> <p>Activity is defined as action. Our past stories and experiences provide us with templates for how we take action in the here and now also for the way in which the outcomes of these actions are linked to the way we intend to take action in the future.</p> <p>Narrative doing is based on reflection and action. Actions taken based on information provided by the resident or their families about their past life experiences and also reflections on their current situation and their interactions with their present environment, are utilised with a narrative doing intention. That is actions/activities engaged in and organised with the resident are based on a mutual interpretation of the hermeneutic meaningfulness ascribed by the resident to both everyday and unusual activities ie. grieving, admission, living arrangement etc.</p>	<p>Enquires if all hobbies, activities, organisations or societies the resident participated in prior to coming into care are taken account of.</p> <p>Enquires if the residents experience of coming into care is recorded ie if they are grieving on admission and how this impacts on their admission</p> <p>Enquires if the way the resident is coping with admission is recorded.</p> <p>Enquires if issues such as grieving or bereavement on admission are acknowledged, and that residents are introduced to the daily operation of the unit and invited to partake in decisions regarding the operation of the unit.</p>

Sampling.

A representative sample of resident records (N=5) from each unit were accessed at both time periods. The records were representative of the male/female demographic of both units with a 70/30 split in favour of the female residents which was similar to the split of females to males on each unit. Each resident record was interrogated using the narrative analysis tool to determine if the documentation

practices of the nursing staff adhered to the elements of the narrative framework and if changes occurred between time 1 and time 2.

Methodology

Data extraction was guided by the operational elements of the framework of narrative practice, narrative being, narrative knowing and narrative doing. Because the framework has not been previously used to investigate nursing documentation practices a pilot using 2 resident records was undertaken to determine if this framework and the data extraction questions were of use for this analysis. Data were extracted from each patient record, using the questions from each of the elements and the relevant sections of the care plan to source the information. Data were analysed and areas where narrative informed documentation practices and non-narrative documentation practices occurred were identified. The pilot confirmed the feasibility of the data extraction questions as a suitable method for collecting this data. Below are two examples of data extracted from the resident records in the pilot that confirms its suitability. Following the pilot study this methodology was utilised for the main collection of data from the selected resident records. Each record was allocated an individual number, to maintain confidentiality and anonymity. Using content analysis (Elo & Kyngas 2008), data were read through and sections with similar meanings or intent grouped together under each of the category headings.

Examples of data extracted from resident records in pilot study.

Narrative Being

1. Is there evidence of two way (between staff/residents, residents/residents) and three way (between residents/relatives,significant others/staff) communication taking place? How is this captured? How is this communication recorded?

There is good evidence of this in Activities Therapy Assessment (ATA) and the care plan (CP) in several ADL sections. It is captured in both the residents own words and subjective comments by staff "I will have to discharge myself if the hoist is being used". M. said she enjoyed outing and looking around the garden centre. M. was looking out for and engaging with other residents at the centre. M. visited by son and daughter brought a wide brimmed hat and sunscreen and took M to the garden, She said she enjoyed the open space. Daughter worried M not settling in ward, Daughter reassured and told by staff that we will try to get M to go to Bingo and other activities. Daughter happy with same

MRN: 80411

Narrative Knowing

5. Is there evidence that the expectations of the resident regarding what they would like from the care experience have been recorded? In what way is this recorded?

In the safe environment section it is recorded that F likes to get up every day and requests to stay in bed when he is tired, that he shouts "hello" if he wants attention. ATA form states he would like to be able to go out downstairs in wheelchair. There is some evidence that this occurs when son visits "F visited by R who took him out in grounds in wheelchair" there is no written evidence that this occurs at other times.

MRN: 473222

Maintaining Credibility and Rigour

In an effort to maintain credibility of this data extraction method both the narrative analysis tool, the data extraction guide, along with the results of the pilot study were critically examined by two expert gerontological nurses. Their concurrence with the sampling method and review of the pilot further confirmed trustworthiness. Maintaining credibility, according to Lincoln and Guba (1985), is one of the most important factors in ascertaining trustworthiness and is important for ensuring confidence in the event under inspection.

Findings

Time 1

The gathering and analysis of data at time 1 took place after the first three reflective work-based learning sessions (narrative practice and culture identification), had occurred and prior to the development and implementation of action plans. The purpose of time 1 analysis was to identify the current or baseline documentation practices of the nursing staff and to identify how much narrative and person-centred information was being captured at this time point.

Narrative Being

Within this element evidence of the type of communication occurring, residents past and present community and family involvements, their views on what is important for a good quality of life and how they respond to change were sought.

Both units recorded communication similarly, with four of the records on unit 1 and four on unit 2, mainly focusing on communication that occurred around tasks

performed and problems that occurred. There was no evidence of any knowledge that residents' interacted or engaged with staff, other residents or family members in a narrative way. Documentation of discussions that took place with family, stated factually that these discussions took place, but did not describe what was actually discussed:

"M. visited today by her sister B who wants to take her out on Saturday, M states she will refuse to come back, this was discussed with B"

T1U1R2

"I. loves chatting and enjoys conversations with staff"

T1U2R3

Evidence of communication between residents and staff was recorded in a superficial subjective way and there was no evidence of documentation written in the words of the resident:

"J. able to express his needs"

T1U1R1

"M. can verbalise what she wants, she always requests to be up for the day."

T1U2R2

and

"B. chatty today...joking with staff"

T1U1R5

In these examples there was no written evidence as to the content of the conversations that occurred or what was actually said by any of the residents.

On both units one resident record did record communication in both a narrative and subjective way. The words of the resident and subjective comments by staff were used in several interactions that occurred:

M is not happy with using the hoist to get in and out of bed states "I will have to discharge myself if the hoist is being used"

T1U1R4

"C. says he feels panicky at times says he takes tablet when he feels like that"

T1U2R5

All of the charts on unit 1 analysed at this time point made no mention of the residents past or present friends. Documentation mainly focused on the present family involvement. There was also little evidence of the residents past involvement in their community prior to admission, with only 1 record mentioning the past community organisations the resident was involved in:

"B. was a member of the local golf club and enjoyed going to golf tournaments"

T1U1R5

On unit 2, while the past community involvement was recorded, there was no evidence that this had been transferred into the plan of care and some of the sections regarding community involvement were left blank on one of the charts analysed:

"hobbies sections are left blank in care plan even though the Activity Therapy Assessment states he likes light opera and dogs, played soccer and likes to watch sport"

T1U2R2

What the residents felt was important for a good quality of life was captured in a generic rather than a personal way within the reassessments that occurs at 10 weekly intervals in all ten charts analysed. However, this was written in a factual way and the documentation did not show if this was translated into the plan of care:

"The Activity Therapy Assessment states he would like to get on his feet and go to a match. There is no evidence that he has been facilitated to attend a match since his admission"

T1U2R5

"loves to be up in the dayroom, loves reading the newspapers and watching television"

T1U1R1

The care plan did not capture if the resident continues to enjoy these activities:

"Activity therapy assessment states visits from wife and family are very important to B."

T1U1R5

There was no additional information regarding how B responded to these visits when they occurred and whether he still felt they were important.

Only 2 records on unit 1, and 1 record on unit 2, showed how the residents responded to change and also what helped them to cope with change:

"reassurance given spoke with her and she became calm and relaxed"

T1U1R2

"Care plan shows that allowing T. time to calm on his own works. T. very angry left on his own for a little while and when I checked on him he had calmed down".

T1U2R1

None of the records documented this in a narrative way using the residents own language instead this was recorded in a subjective way using the observations of the staff and not the feelings of the resident:

"B. appears quiet and withdrawn today this appear to coincide with days when his wife is unable to visit"

T1U1R5

Where this occurred there was no evidence that staff had asked the resident, or attempted to alleviate the situation by engaging with the resident in any proactive way.

On unit 2 staff did attempt to record the feelings of the resident, but they did not use the residents own words to describe what he said when he was angry:

"T. was extremely angry with me. He stated I called the nurse away and that his floor was wet"

T1U2R1

Narrative Knowing

Narrative knowing, is about ensuring that the identity of the person that is rooted in their past, is accounted for in their present and helps to shape the future story of the individual. It is about perceiving and understanding the individual, taking account of their present status, but being mindful of their past life story.

What the resident expected from the care experience was not captured well in unit 1. All five charts reviewed had no evidence that any discussion took place regarding the residents expectations of care. The only discussions that were documented were focused on activities or mobilisation. In one chart, where the resident expressed a wish to go home, there was no documented evidence of how this was addressed, or what was done to help the resident address these feelings:

"this place is like a workhouse" "I would be better off at home".

T1U1R1

Residents expectations regarding the care experience were captured in a more comprehensive way on unit 2 and included both social and personal activities. Encouraging the resident to be involved in decisions and offering choice were also included. However, there was evidence that these expectations were often only facilitated sporadically:

"Activity Therapy Assessment states that F likes to go downstairs in wheelchair. There is evidence that this occurs when son visits. F. visited by R. who took him out in grounds in wheelchair. There is no written evidence that this occurs at other times".

T1U2R2

In all charts analysed, on both units, the resident's previous lifestyle were recorded well. However, in some charts there was conflicting information between what was recorded in the ATA and the admission assessment form. Often the information in the Activity Therapy Assessment was more comprehensive and this information was not transferred to the care plan:

"Recorded in both the Activities Therapy Assessment (ATA) and Admission assessment form. The information in the ATA is more informative states bred greyhounds and played hurling finds it hard to relax. Does not like TV except for sport programmes. Most significant memory winning hurling medal and beating Tipp. Favourite events greyhound racing, hurling and rugby. In the ATA it states likes music but the admission assessment states he does not like music. Both forms record marital status as married with no children. The ATA states wife's name and that she is a good support"

T1U2R5

The previous life status of the resident was recorded intermittently in the charts analysed on unit 1. Mostly status was recorded in relation to work history or in relation to family status, status in the community was not recorded.

"The only information regarding status is his working life status "worked as an electrician". It doesn't specify where he worked and at what level he worked. There is no mention of his involvement in the local community and where he was placed in this or also his standing in his own family ie eldest/youngest sisters/brothers etc"

T1U1R1

While the life status was captured better on unit 2 often the information provided in the ATA conflicted with the information in the admission assessment form and the information was not transferred into the care plan:

"ATA records he was a baker on a Navy ship, used to travelling and was part of the ships sports teams, Was the father of 4 boys and was married to N. None of this information is captured in or informs care in the Care plan"

T1U2R2

On both units, residents' feelings regarding the loss of their previous lifestyle, status and abilities were recorded in relation to reason for admission, but not in relation to how the resident felt about losses. Where the record stated the resident was aware of reasons for admission the feelings around this were not explored or documented:

"Activity therapy assessment states fully aware of abilities and interests "I can't do anything now I find it hard to relax". It doesn't state how he feels about this or that any discussion has occurred about maximising the things he is able to do. This information is not transferred to plan of care."

T1U2R5

"Activity therapy assessment states it annoys her that she is unable to do the things she used to enjoy. "she feels that due to physical deterioration she can no longer do knitting which she love" This is not translated to the care plan and there is no evidence that any effort has been made to a similar occupation that matches her interest and abilities."

T1U1R1

Residents decisions regarding their care were recorded in both units in relation to issues and problems. There was no evidence that the daily care experience and issues around that were discussed with the resident. Discussions mostly focused on risk and clinical problems, and not on what the resident wanted their day to day care to be. Some charts had no evidence of any discussion around this:

"Care plan evaluation states care planning decisions are discussed with B. and with his wife C. There is no documented evidence what these discussions are or of how B. feels about them"

T1U1R5

"F is complaining of pain in his joints. He is on regular analgesia which is effective. Slow movements are suitable for F. Changing his position also helps with pain". There is no written evidence that any discussion has occurred with F regarding whether he thinks this treatment is effective or if he wishes to continue it or try an alternative".

T1U2R1

The way in which the resident's insight into their safety limitations were recorded was similar in both units. Documentation mostly focused on the use of risk limiting devices such as bed rails and advice and instructions given post falls. However, the

documentation lacked any in-depth discussion with the residents and also failed to state if the resident understood rationale for decisions made:

"I. feels secure when bed rails are up" The mobility section of the care plan states "I. needs help in transferring and her safety awareness is poor it does not state how this is demonstrated."

T1U2R4

One resident record on unit 1 did record the resident's insights in both a subjective and narrative way:

*"M. vague at times has little comprehension of her abilities, thinks she can transfer without help but in reality needs the assist of 1-2 people". (6/6/12)
"M transferred herself to toilet but was unable to adjust her clothes. She was distressed and said " I think I am able to do more than I can" (13/6/12)
Found sitting on toilet after transferring herself to the toilet, she did not ring for assistance poor safety awareness limited understanding of abilities"*

T1U1R4

In both units at time one , there was no documented evidence that the residents had been introduced to everyone on the unit and all but one record had no evidence of how the residents interacted with other residents:

"This is not recorded in any formal way. M takes part in the activities organised on the unit and by the activities team. "M went to Mass with the activities nurse". There is no documented evidence that M interacts with any other resident on the unit"

T1U1R2

On Unit 2 one record did document that the resident interacted with some of the other residents:

"Social activity section of care plan states. "M. loves to socialise with other residents, she requests to go to the sitting room during the day, they play cards and she is the lead in chats, she also actively partakes in bingo on Thursdays".

T1U2R3

Narrative Doing

Narrative doing is based on intentional action. It is concerned with ensuring that all activity that takes place with residents is meaningful, and that residents' past interests and activities are incorporated into their everyday care. It is also concerned with ensuring that everyday activities and unusual activities, such as grief and loss, are discussed and a shared understanding of how the resident deals with these issues is reached.

On unit 1 all but one of the records analysed recorded the residents past hobbies, activities and society involvement well. Only three of these records transferred this into the current plan of care, where there was evidence of continuation of these interests in the day to day living of the residents:

“There is evidence in both the Activity Therapy Assessment and Care plan that M. continues with the hobbies she can do since admission and that social engagement with her family also continues. “M. continues to do her needlework, enjoys the paper and visits from family”. “visited by daughter today went for a stroll in the grounds, both appeared to enjoy same.” Visit from Harry (dog) today M. very interactive, chatting about her own dogs that she had before coming into ward”

T1U1R4

There was no evidence of these interests being transferred or integrated into the daily care of the other two resident records examined:

“Recorded well in the Activity Therapy Assessment states “liked knitting aran patterns, rounders and GAA, liked to listen to irish music and read the papers, enjoys shopping” This is not recorded or transferred to the social activity section of the Care plan.”

T1U1R2

Unit 2 had similar findings, two records showed recording and integration of past interests into current plans of care, and three showed limited recording, with no integration into care plan:

“The social activity section captures this in a small way. Music news, sport and playing cards are all ticked off but it does not specify what type of music or what card games he enjoys. The Activity Therapy Assessment also states he enjoyed greyhound racing, bred dogs, enjoyed hurling and rugby but this is not recorded in the care plan.”

T1U2R5

Only one record examined (T1U2R1), recorded the resident's feelings regarding their admission to long term care:

“Admission assessment states “I was unable to cope at home because of the stroke”. Elsewhere it states “happy to be here but would prefer to be at home”

T1U2R1

All other records examined did not record this information or recorded the nurses reasons for admission rather than the residents feelings or understandings:

Admission assessment states “ admission to long term care because he is unable to mobilise”. There is no documented evidence regarding how the resident feels about this.

T1U1R5

In one case, a resident (T1U1R4) had been transferred from the rehabilitation ward to one long term care ward and then to the present unit. This was because of reconfiguration of services and the closure of the first ward. There was no evidence that any discussion took place with this resident regarding these multiple relocations and how they felt about it:

CP does state family aware of transfer. Transfer note states she appears to be calm but no in-depth information regarding her thoughts on the moves"

T1U1R4

Only two resident records, one from each unit, recorded the residents involvement in ward meetings and residents forums:

M. does take part in the residents forum meetings and this is stated in several places in the care plan. " attended residents forum meeting today appeared to enjoy it"

T1U1R4

However, there was no indication as to how this involvement helped to shape the way operational decisions were made with residents' involvement on each unit. All other records investigated did not have any evidence that residents had been engaged with in a proactive way, to elicit their views on how the unit should operate or be improved:

"No there is no documented evidence of formal or informal ward meetings between staff and residents No documented evidence in care plan regarding any involvement by the resident in changing or shaping his own sleeping area or in the communal areas of the ward."

T1U2R2

Overall, in all five records reviewed, on unit 1 narrative being and narrative knowing were captured in a limited way. Therefore narrative doing was not addressed well. Any narrative doing that was documented was not based on either narrative knowing or narrative being, and did not address issues of concern such as anxiety and frustration experienced by residents:

"Captured in a limited way and mostly in relation to the activities the resident takes part in. Values such as outings and trips to Mass are continued, "M enjoys outing with the activities nurse" "attended Mass in St. Pats enjoyed same". However her obvious anxiety at increasing dependency and frustration with the care experience is not addressed. There is also no evidence that the resident interacts with anyone other than the staff and her family on the unit"

T1U1R2

On unit 2 the narrative being and narrative knowing of residents were captured well, but this was not translated into narrative doing in all but one resident record:

“There is evidence that both narrative being and narrative knowing are captured in a narrative doing way with this resident. His past hobbies and social activities are incorporated into his present care. There is also evidence that his thoughts about his admission are acknowledged. It is evident that staff know T. very well and know that when he is upset or angry he calms down best if left alone. There is also evidence when issues are identified such as problems with swallow, appropriate action is taken, but that T.’s own feelings are also taken into consideration and he continues to live in a manner that increases his quality of life and promotes his personhood.”

T1U2R1

The results of the analysis that occurred at time 1 were discussed with the staff at reflective work-based learning days. They used this information to identify areas of documentation practice that could be improved. The two units collaborated and set up a working group that included myself and two nurses from each unit, to look at ways of improving documentation. With input from other staff on the units, this group developed a prompt sheet (Appendix 19), that staff felt would help them be mindful of narrative approaches to care and narrative documentation practices.

Development of prompts to promote writing in a narrative way sheet.

This working group met three times to look at developing a one page sheet that could be placed in each residents care plan. The purpose of the sheet was to remind staff to consider the way they were documenting the care given. The results from time 1 documentary analysis, and input from staff gathered following feedback of these results, helped inform this group of areas where improvement could occur. The group looked at three areas, documenting from the perspective of the resident not the carer, documenting in residents own words including their feelings about care, and documenting residents expectations about how they would like the daily care carried out. The group also looked at other helpful ways to increase narrative interaction and to document this interaction in a narrative way, they included these in the prompt sheet also. The staff came up with a short list of what they thought would be most helpful to have on a prompt sheet. All present agreed that the prompt sheet should have only a few prompts as otherwise staff would not use it. They felt that if the prompts also gave examples of narrative documentation and what was not narrative this would be very helpful. The group agreed that there were three main areas that needed to be addressed to ensure that narrative

documentation was occurring. They felt the areas they had outlined addressed narrative being, narrative knowing and narrative doing. The areas they highlighted were:

- writing from the perspective of the resident addressed meaningful communication.
- recording their feelings and desires addressed finding out desired expectations
- documenting conversations that centred around how the resident would like their day to go addressed narrative doing.

Rough drafts of the sheet were taken back to each unit and refined based on comments and suggestions from all staff at subsequent meetings. At the third meeting a final version of the prompt sheet (Appendix 19) was agreed by the group and this version was returned to both units. On unit 1 the prompt sheet was placed at the front of each residents care plan and on unit 2 staff placed it at the back. Staff on each unit choose the place to display the sheet based on where they felt it would be most effective and easily accessed when they were documenting care.

Time 2 Documentary analysis

Documentary analysis occurred at time 2 after reflective work-based learning session 8, the implementation of action plans (working in a storied way) and introduction of the prompt sheet. The purpose of this analysis was to interrogate the data to ascertain the documentary practices at this time point, to identify if changes had occurred between time 1 and time 2. This analysis also considered if the documentation practices were narrative informed and person-centred.

Narrative Being Time 2

At time 2, both units had shown considerable improvement in the type of communication that was occurring and being recorded in the residents care plans. All records reviewed showed good evidence of communication between staff, residents and relatives:

"This is captured well in the Social activity section. "W visited a fellow resident who is ill and both were delighted to see one another". "W went downstairs to visit his friend and play cards". "W enjoyed the chat and crack with the staff in the dayroom." "W having a laugh with the staff about the greyhound races"."

T2U1R2

This was in contrast to time 1 where the staff did not record the content of conversations and where most communication occurred around specific tasks.

There was also evidence that attempts were made to elicit the wishes of residents who had difficulty communicating by observing their reaction to care episodes:

"J is unable to express his wishes due to expressive dysphasia but staff have noted in the care plan how he reacts to interactions with others J visited by wife P and family " J likes being with people goes out daily if weather permits on the grounds with wife, he enjoys these outings."

T2U2R5

Both units also captured the residents past and present community and family/friends involvement well. The present activities that residents took part in were linked to past hobbies and integrated into their current plan of care. . This contrasted with no recording of this information at time 1 on unit 1 and no integration of the recorded information into the care plan on unit 2:

"Recorded well in the ATA form "loved to watch tennis, snooker and golf. Liked art" Also recorded well in social activities ADL. T continues to take part in art "T doing Arts and Crafts with Ciara in dayroom. She also went to Gold ward today to make Christmas cards" "

T2U2R3

Staff used both narrative and subjective documentation to record this information. The residents past links with friends from their community and to past home and social life were maintained in the present visits and outings:

"Captured well in Activity therapy assessment . Family involvement capture in care plan evaluation and social activity form "D won a prize at Bingo today was surprised said, !I never won anything. Currently being visited by wife E and daughter L. enjoying the visit. Went to art therapy this morning in the garden. (D used to paint as a hobby and enjoyed outdoor activities). "D enjoyed watching the Olympics" (this marries with the ATA form which states D loved all sport)."

T2U1R5

The residents views on what they thought important for a good quality of life was recorded well in all ten records reviewed. The information was recorded in both the residents own words in a narrative way:

"L says she likes to chat but likes time on her own without intrusion also."

T2U1R2

This was also recorded in a factual way from observations made by the staff, of the residents reactions to situations, or in the case of one resident, identifying triggers that caused agitation:

“Residents views on quality of life is not captured due to J’s inability to express his wishes. Staff have recorded when he is relaxed and if he becomes agitated. They have also recognised the triggers to his agitation. “J was quiet and relaxed resting on his bed, while I chatted to him”. “ was very breathless and agitated on return to ward from party in Activities centre. Wife states he was in good form at the party and only became agitated when getting off the transport van on return”

T2U2R4

The information gathered for this element at this time point was vastly improved from time 1 where all 10 charts reviewed documented this information in a factual way and there was no evidence that the information was translated into the plan of care.

At time 1 only two records on unit 1, and one record on unit 2 ,recorded the residents response to change. At time 2 all ten records recorded how the residents reacted to changes in both medical and social conditions:

“Care plan states can get confused at times “this is related to low blood sugars and can occur if she gets a UTI “. Staff have recognised that her low blood sugars can lead to confusion. “R remains pleasantly confused blood sugars monitored at 6am and 3pm”. “ R prone to UTIs extra fluids and cranberry juice taken daily.”

T2U2R1

There was still some discrepancy between narrative documentation and factual recording, with only 2 records on both units recording residents' responses in their own words:

“During admission N’s room had to be changed , the documentation states she responded well to this and her mood did not change. “N likes the new room, she says she is happy there “

T2U1R1

Narrative Knowing Time 2

At time 1 all five records analysed on unit 1 had no evidence of any discussion taking place around residents' expectations of the care experience. While Unit 2 did capture this information, expectations were only facilitated sporadically. At time 2

both units displayed good evidence of this information being sought and documented in both a factual and narrative way:

"Admission assessment form: "I am delighted to be here would like to be able to go to bed late and don't mind when I get up" " W. has no particular food preferences" " likes meeting people and going on outings".

T2U2R2

Residents' wishes and views were sought and integrated into the plan of care:

Care plan states L. doesn't want to be bothered by too many questions says she finds this intrusive. Staff have respected this. L. does like to chat from time to time and staff have recorded the information from these chats to help inform care. " spoke to L about old times today and what it was like for her" "L loved the outdoors hated being cooped up inside and went for very long walks in the hills"

T2U1R2

Residents' previous lifestyle had been recorded well at time 1 but not integrated into the plan of care. At time 2 both units again recorded this information well using the ATA, but at this time point they integrated this information into the care plan and included both social and occupational details, along with links to the community:

" Recorded in the ATA and Admission assessment chart. Liked outdoor walks, dressmaking , watching TV, and playing cards. This is integrated well in CP and staff engage L in these activities. " L played 45 last week likes to go to the dayroom at activity time."

T2U1R2

The residents previous life status had been recorded intermittently on unit 1 and recorded but not transferred into the plan of care on unit 2. At time 2 both units were consistently recording life status information and also using it in the care plans. On unit 1 background, historical information was also captured:

"Activity therapy assessment states previous occupation was a milkman," D was known as D the Milkman, most of the people on his round on the northside did not know his surname", widowed, had 5 children, J M J P + J. was 1 of 10 children is close to nieces and nephews and grandchildren. Played football with Ballingearry and was close to his neighbours. His favourite event is family gatherings. "lived in Gaeltacht region, Enjoyed speaking a cupla focal"

T2U1R4

On unit 1 the residents feelings about the loss of their previous lifestyle, status and abilities was still not recorded or assessed well at time 2. This was similar to time 1 where both units did not record this information well:

"Residents mood appears pragmatic. ADL section 7 states knows she is unable to manage at home, does not want to be a burden on her daughter. The biographical section states "understanding of admission is for Long term care.""

T2U1R1

However, at time 2, unit 2 had made significant improvements in the way this information was captured:

"ADL admission assessment states "he is unable to continue to do the things he did before his stroke but says he is happy to be here as he needs the help"."

T2U2R2

There was good evidence of discussions with residents about decisions regarding their care at time 2 on both units. This contrasted with time 1, where there was no evidence, on either unit, that residents decisions regarding their care were recorded or considered. When documenting these discussions staff now wrote what the discussion was and included the residents own words:

"Recorded in a narrative way in the care plan evaluation in the way that she interacts with other residents and in relation to physical care and activities. "I don't feel like eating, I don't know what's wrong I will come around later" Asked R if she has any pain she said "no just a little stiffness" R watched flower arranging but did not participate said "she just wanted to watch for now" . Asked R if she wanted to go to Mass but she refused said she did not wish to go today maybe tomorrow"

T2U2R1

and

"Good evidence that discussion takes place around care needs for example in choosing new wheelchair and in deciding to get up or stay in bed. D also chooses what activities he is involved in "D states he is happy and comfortable with new chair" D went to sonas today and enjoyed conversation with the students from the school of music. Stated he had a great time and would like to go again "

T2U1R3

The documentation regarding residents insights into their safety limitations continued to focus on safety devices at time 2 on both units. However, at this time point the documentation showed engagement with the residents regarding safety issues and also their input into their care planning:

"W fully aware of safety limitations" W requested bed rails up said "I feel safer having them up it helps me move in bed" "

T2U2R 3

All records investigated, at time 2, showed that residents interactions and socialisation with other residents and with staff were recorded well. This contrasts with time 1, where only 1 record on unit 2 showed the interaction that occurred between residents:

"Recorded in several places in the care plan that W interacts well with the staff and other residents. "W discussing his night at the dogs with everyone in dayroom he said he had a great night". "W and T having a chat and playing a game of cards". " W went to activities centre to take part in art with other residents""

T2U2R2.

Narrative Doing Time 2

All records at time 2 recorded the hobbies, activities and societies that residents had taken part in prior to admission. This information was also utilised in residents' care plans to inform and plan their care. This showed an improvement from time 1, where information was recorded in all but 1 record but was not transferred into the plan of care, for 2 records on unit 1 and 3 on unit 2:

"Matches, reading outings and Mass all continue W is a member of the hospital boccia team and has represented the hospital at several tournaments. "W out to Cobh today for boccia tournament, team won 1st prize W said he had a great time". W went on a trip to the dogs last night said "it was a great night I won 5 races I had fun hope we go again". "

T2U2R2

At time 2 the way both units recorded residents feelings about being admitted to long-term care remained a problem. Neither unit had made improvements with records examined, recording medical or social reasons for admission and not the feelings and concerns of residents:

"Recorded in the mental status section and biographical details. "Resident aware of her declining health and need for care states she doesn't want to be a burden and needs long-term care""

T2U1R1

The way that residents were involved with decisions regarding the daily operation and improvements in each unit, continued to happen in a haphazard way. On unit 1 only 1 record recorded any evidence of residents' involvement in the residents forum or meetings. On unit 2 there was significant improvement, with all 5 records reviewed showing some type of engagement with residents regarding these decisions, as opposed to only 2 recordings at time 1:

"T attends the residents forum meetings where issues related to the operation of the hospital are discussed. When she wanted to change her

bed this was negotiated with staff and she was involved in deciding where her new bed would be."

T2U2R3

Overall, at time 2, both units showed a marked improvement in the way both narrative being and narrative knowing were captured. While there were still some areas that needed improvement, notably areas where residents insights and feelings were recorded, this did not affect the way narrative doing was captured. At time 2 narrative doing was informed by narrative being and narrative knowing, residents past life and interests were used to inform their present care plans. Residents were involved, to some extent on unit 1, and a greater extent on unit 2, in decisions around operational and organisational improvements on the units:

"where possible there is evidence that the knowing and being of the resident are addressed in the doing. Activates such as cards and bingo continue. Being with and chatting to people was important to L and this continues with visits from family and old friends. L also interacts with the other residents in the group activities and in the reminiscence sessions."

T2U1R3

"The narrative being and knowing of the resident are continued in the narrative doing. Activities she was previously involved in are continues in her present care. Her likes and preferences are acknowledged as well. She continues to interact with her family and go on outings. Her love of reading the daily newspaper continues and she continues to go to bingo and take part in art. She is an active member of the residents forum and as such is able to shape the care experience for both herself and other residents."

T2U2R1

The documentary analysis at time 2 confirmed that staff were utilising the framework of narrative practice in both their care practices and documentary practices. It highlighted areas where further work needed to be undertaken, such as identifying and eliciting feelings of residents, regarding their admission to long term care and loss of lifestyle, status and abilities. Staff confirmed the implementation of the prompt sheet after time 1 analysis reminded them to write in a narrative way when documenting. Both the narrative prompt sheet and ongoing work-based learning reflective days helped staff engage with residents in a person-centred way. It also helped to ensure that this engagement was transferred to the residents record in a way that privileged the residents' own words. A limitation of the documentary analysis was that it only confirmed what staff had actually documented in the residents records. For this reason an overarching evaluation was also carried out as discussed below.

Overarching Evaluation

While the documentary analysis occurred separately and informed both the work-based learning days and the way documentation occurred, it also formed part of the overarching evaluation. As outlined in the introduction to this chapter overarching evaluation occurred at midpoint (9 months after implementation) and after completion of the work-based learning reflective sessions (18 months after implementation). All data collected as part of the work-based learning activities, research field notes, the researchers reflections, meeting notes and minutes, and information gathered in the documentary analysis activity, were used to inform this evaluation at both time points. Effective evaluation is concerned, not only, with using methods that ensure feedback, on the change of practice and how successful it was, but effective evaluation should also draw attention to any obstacles or hurdles to that change (McCormack & Buckley 2014). Therefore, the purpose of this overarching evaluation at time¹ was to identify the way the implementation was occurring and to identify any potential barriers to the future implementation. At time² the purpose was to consider the overall effectiveness of the implementation on the quality of life of the residents and the care practices of the staff. I along with two experts conducted the evaluation at both time points, using creative hermeneutic data analysis. This critically creative method of analysis has been fully explained in Chapter 5 p.89. The approach adopts Gadamar's (1995) philosophical perspective of allowing oneself to be questioned by the data, developing an intuitive grasp of the data and examining that to develop themes, patterns or connections.

Using all the data generated by the research project as outlined above each person created an image of their conceptualisation of the data, told the story of their creation to another person who wrote that story verbatim. Together we looked at the combined stories and extrapolated themes based on recurring and similar ideas in the written and creative images. These themes were then used to write a metanarrative of the data.

Story of the Creative Data Unit 1 Time 1

Having looked at a representation of the data each of us created images of our understanding of the data from unit 1 at time 1. While each person's perspective was unique there was some overlap between the images represented.



A



B



C

Using these three images we told each other the story of our creations. The following is the verbatim accounts as described by the three of us. They are written here as they were freely described by us, without consideration for grammar or syntax. This is in order to remain true to the creative process of maintaining the verbatim account of each person.

A

Mountain represents hierarchy. Kings hat represents the boss. loudspeaker and boot mean will talk the talk but not walk the walk. There is a doing approach to care and discussion about doing it better. There is some sparkle here - staff trying to change. Good communication between staff although the care staff had no idea

about what was going on with residents. Residents are peaking around side of mountain. There is a big barrier between the CNM and the staff. Looking down from top of wall and dictating what way to staff. Some evidence of enlightenment of staff, they see how it could happen but are unable to make it so. Information is not shared here it is very much nurse centred.

B

A wall reflecting a barrier between the CNM on the outside and residents and staff on the inside. A sense of a dark cloud hanging over proceedings when the CNM is present. The CNM is a big part of the picture but the CNM does not want to ask the questions in the context of the narrative approach. Inside the ward it was a sunnier place and some examples of narrative/life story work. Some staff enthusiastic and a positive approach but uncertain re how to ask the questions or document it.

C

What I represented was a feeling of greyness about the whole thing. Very little sparkle - hints of sparkle when there was potential for elegance and an awareness. They were able to spot where narrative was and they recognised the essence of people represented by tiny bits of sparkle, but it went nowhere. It's all words. The observation and the discussions showed a disconnect between the spoken words and what they recognised as the practice. The people show the contrast of the concretisation of the person almost like black and white. People can hear and acknowledge when the person was a baker etc. but this is not translated into practice. There are 1 or 2 examples of multi-colouredness of the person but this is more connected to how narrative could help then see more of the person.

After recounting our stories to one another we next agreed a meta narrative that collectively captured our thoughts about the representations of the culture.

Metanarrative Unit 1 Time 1.

This place is very grey. Feelings of control and a sense of someone overpowering. Things happen here in a black and white way, there is a one way only way feel about it. Concrete walls block contact or change and there is no way around. Fleeting patches of brightness shine through there is no substance. Paths lead the

way forward but no-one follows the signs or tells others how to find the way. We talk a good talk here but our boots are not made for walking.

We critically looked at the meta narrative and together agreed the following themes:

Themes Unit 1 Time 1

1. Concretisation of the person
2. Meaning/taken for grantedness of words.
3. control/power
4. Communication
5. Lack of recognition of processes.

1. Concretisation of the person relates to both the staff and resident. It involves the relationships that occur or do not occur between them. In this setting the relationships are almost black and white, there is no room for in between. There is a way of doing things and there is no deviation from that. Some evidence of knowing the resident is shown but this is not translated into practice. This is also manifest in the way the manager interacts with the staff in a very much top down approach. Barriers/walls that are built up keep a distance between the manager and the staff and between the staff and the residents.

2. Meaning /taken for grantedness of words - there is a lot of talk in the setting about using a narrative approach but mostly these words don't have any meaning or are not used in a meaningful way. They are very much taken for granted. The spoken words do not match what is happening in practice.

3. Control/Power – related to the management of the ward and how the hierarchy affects the way the staff engage with the narrative approach. The influence and control of the manager affects the way care is carried out in a very much task orientated way with little account given to changing the way things are currently happening.

4. Communication - related to talking the talk but not walking the walk. Communication is very much nurse centred with certain aspects being kept within the nursing domain and not shared between all grades of staff. It also relates to the way there is a disconnect between what is espoused and what is practiced. There

is a good recognition of what constitutes a narrative approach and a recognition of the essence of people but it goes nowhere. There is also uncertainty among the staff about how to ask questions about the narrative approach.

5. Lack of recognition of processes- staff recognised and had an awareness of the person and sometimes captured this in documentation but they still lacked a recognition of processes to utilise or translate this into practice.

Similarly for unit 2 we again created images that represented our interpretation of the data.



A



B



C

Story of the Creative Data Unit 2 Time 1

A

Flat structure - CNM, residents, staff. A sunny environment everyone is happy. The book represents the biographical information that the staff have about residents. The sieve sifts the biographical info the staff have and it is not always evident in the documentation. The arrow represents the staff knowing what they need to do to change and develop. There will be blocks along the way. They have the strength (muscles) to get there and all going in the same direction.

B

This is an inclusive picture - there are no walls or barriers. This is a flat system. There are no tall poppies here - everyone is included and equal. Holding hands showing equality and lots of caring. There is difference and diversity. Pockets of change and patches of good practice. There is 2 way communication - everyone knows exactly what goes on and staff address issues with residents. There is lots of respect by the CNM for the staff - issues of concern to staff are addressed.

C

Yellow is an amazing bed of energy. There is colour and vibrancy - it is a source for being creative and to grow and develop and change and practice effectively. It feels colourful and has energy. Four interlocking spirals and the energy is captured in the staff in the way they talk about change, they are not being hindered - largely equal represented by the different shades. There is a diversity and it is captured. It is used effectively in the way they work. The spirals represent how the staff work with the residents. The potential is enormous, the squiggly lines represent the energy and it is easy to harness because of the way they work.

Metanarrative Unit 2 Time 1

Yellow is the sunshine that shines in this place. There is a vibrancy and an energy to the work and in the talk. Happy people caring for one another. We are going somewhere here. Gentleness kindness and respect abound and opportunities for growth are promoted. Care is everyone's responsibility.

After describing our metanarrative the following themes were agreed:

Theme Unit 2 Time 1

1. Colour (Concreteness)
2. Power/Influence
3. Energy
4. Empowerment.

1. Colour relates to the vibrancy in this site, it is demonstrated in the creativeness and diversity that is both valued and utilised by the site. The colour also represents the knowledge staff have that enables growth and development.

2. Power/Influence – this is demonstrated in the way the staff act and interact with each other and with the residents. There is equality demonstrated in the way they show caring for the residents by ensuring that all staff are aware of any issues that residents have but also in the way they show caring for one another. This is demonstrated by the CNM who recognises the anxieties and issues staff have.

3. Energy - is captured in the way change is talked about by staff and how this enthusiasm is harnessed and used to develop narrative practice. There is evidence of the development of good practice in the way discussions take place with the residents and how information gained is acted upon. The energy is also shown in the strength of the staff and their ability to move forward with everyone going in the same direction.

4. Empowerment - is shown in the way the staff work. There is equality across all grades and all have equal knowledge and are working together to make their practice more narrative. There is ownership demonstrated in the type of communication that occurs and in the respect that is shown by the CNM for the staff. Empowerment is also demonstrated in the autonomy staff have to address issues with the residents.

At time one the data showed a marked difference between the way unit 1 and unit 2 engaged in the implementation of the framework. The influence of the CNM on unit 1 controlled the way staff implemented a narrative approach. While there was some recognition of the resident as a person and staff were willing to undertake a change

they were fearful of the CNM and deferred all decisions to her. The data showed a disconnect between the spoken word (what staff said they were doing) and what staff recognised as the practice or what needed to change. On unit 2, the approach undertaken was very different and this was demonstrated in the themes identified. There was very much a flat structure with everyone having equal status. The staff were aware of what constitutes a narrative approach but did not always translate this into the documentation. On this unit at time 1 the data showed a concerted effort from all involved to move in the right direction. While they did not always get it right at this time point they were talking about change and using this effectively in the way they worked.

At time 2 the researcher and two experts again employed a critical creative hermeneutic data analysis (Boomer & McCormack 2010) approach to the evaluation of the implementation of the framework of narrative practice on both units. We again creatively conceptualised our understanding of the collective data from time 1 to time 2 and identified themes for both units as follow:

Story of the Creative Data Unit 1 Time 2



A



B



C

A

Generally a dark sludgy environment

Brown= potential in the documentation, able to write expressed practice

Gold paint representing potential

purple= religion artifact =suffering cloak over the face - face has open eyes, red lips representing voice of staff and residents other half of face demonstrates voice not heard - drowned out.

Rt hand side colour and stars drowned out by cloak.

not coherent- if left long enough will blend together and not add anything to the whole cloak.

B

purple zig zag represents a barrier. Dark cloud on one side the other world has just one ray of sunshine trying to break through. Lips represent the lip service that appears to be offered to the project by most of the staff. It is also possible that the staff were only in a position to verbally support the proposed changes as they were never going to be facilitated to implement a narrative approach to care in practice with the present management structure. A sense of staff and residents stuck in middle between reality and trying to get out of it. Ring representing lack of commitment (uncertainty) sits on the fence. May be a move from the dark to the less dark but sun will not light up the way.

C

The blue circles represent what I feel is a presence or element that impacts on what is happening here. It is circular as sometimes it is ok but it is always turning back on itself. The book represents the documentation which does appear to have improved. Brown paper = barriers that are hindering progress and that collectively form one barrier that they cannot get past. Flowers represent the tall poppy syndrome in the unit and so people with potential are being held back/broken. Orange and purple colours represent the factors that broke the people with potential.

Metanarrative Unit 1 Time 2

Darkness and uncertainty abound. There is no way forward. A dark clock covers all and prevents movement. Lots of talking little doing, no commitment. Voices without sound, sound without meaning, doing without action. A ray breaks through but is quickly consumed by the darkness.

Themes Unit 1 Time 2

1. Overshadowed
2. Voiceless
3. Espoused being
4. Lack of commitment

1. Overshadowed

The data shows that the potential of the staff is overshadowed by a presence or element that cloaks or masks their ability. While there is some potential shown within the documentation practices of the staff it is not clear if this is translated into practice. The data shows a movement towards new ways of working with some areas of sunshine trying to break through, but there is a constant turning back to old ways of working with little attention paid to the implementation of the new ways. Areas of potential or innovation are quickly drowned out by the oppression of the veil and how it impacts on the ways of working of the staff. There is evidence that the staff and residents are aware of this but their voices are not heard they are drowned out. Two factors have significant impact on this. These are the manager's need to control and direct all situations and the staff's inability or lack of desire to challenge this.

2. Voiceless

Voiceless relates to the walls that are built up between the staff and the residents and also between the manager and the staff. These barriers take the form of a hierarchical leadership with little potential for innovation or risk taking by staff. The data demonstrates that staff have a fear of making decisions and do not have the autonomy to implement change. Their voice is not heard. Where staff have challenged and attempted to implement change there has been a general consensus and agreement to try the change but after a brief period things have reverted to old patterns.

3. Espoused being

The data shows that the staff on this unit only offered lip service to the project. While the espoused values were to implement the Narrative Framework this was not carried out in practice. Throughout the programme days staff were knowledgeable of the narrative approach to care and could cite several areas where a narrative approach would help improve care. However, they did not implement the framework in a meaningful way, rather they implemented it in a very technical task orientated way by developing a suite of communication tools. These tools privileged the staff, and while they may have improved the care of the residents, they did not acknowledge the personhood or narrative of the resident.

4. Lack of commitment

Lack of commitment or uncertainty is demonstrated in several ways. There was a constant battle to ensure that programme days happened with several cancellations and rescheduling. This demonstrated not only a lack of commitment but also a lack of respect for the process and the researcher. The data shows that between the middle and towards the end of the programme the staff had begun to demonstrate an ability to have a voice and to attempt to make decisions and were very participative in the development of the prompt for narrative writing tool however, at the end of the project this had disappeared to be replaced by apathy and negativity with staff evaluating their participation in the project in terms of the extra workload and time commitment it had caused them. The analysis for unit 2 followed a similar approach

Story of the Creative Data Unit 2 Time 2



A



B



C

A

Seeing huge potential for growth and growth of the people. Growth in lots of different directions. Very rooted and embedded in the culture. A very bright impression of light in the data but generally everything that was welcoming and is busy and moving and good.. Things are happening but the happening is joined up to growth and to the light in a synergistic relationship.

B

vibrant place

lots of pieces that fit together neatly.

consequences of patients and staff working together.

The data has a core (middle of the flower) has a heart that is vibrant. It all fits has a centredness- has a definite form.

Systematic - have conversations about what works and needs to change lovely.

C

Big sun bright environment. The eyes were half closed at the beginning but then the eyes opened. Equal standing of everyone as a team. pink flower people have questions and are able to ask them they have the ability to do that and flourish.

Metanarrative Unit 2 Time 2

Lightness brightness and energy everywhere. The jigsaw is fitting together well and it has a heart. Conversations lead to questions, question lead to answers, answers lead to growth and becomes part of culture. Vibrancy, synergy and growth are happening here.

Themes Unit 2 Time 2

1. Centredness
2. Vibrancy
3. Synergy

1. Centredness

Centredness in the data is demonstrated in the way collaboration takes place between staff and residents. There is an embeddedness of narrative ways of working in the practice and in the culture. The data demonstrates a core or centre that is vibrant and that enables different methods and ways to fit together. There is a recognition of everyone's ideas and contributions.

2.Vibrancy.

The data demonstrates a growth in the way the staff are thinking, looking at and developing strategies to deal with problems or to develop practice. It also demonstrates personal and professional growth of the individuals involved in the programme with several staff taking on leadership roles within the unit and leading on different actions. There is no hierarchical structure demonstrated on this unit, staff are encouraged to develop ways of working that help to improve the lives of the residents and everyone's ideas are welcomed. The data shows that there are lots of

different actions happening but that these actions fit together neatly in a considered way and that staff have been critically reflective and inclusive of the residents in the development of these actions.

3. Synergy

There is evidence that everyone in the team is included and has equal standing. Staff and residents working together collaboratively. There is movement and light which shows an awaking and realisation of the importance of these relationships. Synergistic relationships are linked to growth and centredness in a joined up way. Staff take account of the effects of these relationships and how they impact on the care of the residents. They have conversations about what works and what needs to change in a reflective way.

At this time point unit 1 did not show any vast improvement with a change in culture to one of narrative informed practice nor did they demonstrate any desire to challenge some of the barriers that were holding them back. They did continue to demonstrate potential for growth and this was evidenced in the change and improvement in their documentary practices. However the CNM continued to be an influence on the way the staff engaged. It is possible that the staff were only in a position to verbally support the proposed changes, as they were never going to be facilitated to implement a narrative approach to care in practice, with the present management structure. At time 2 there was a clear lack of commitment to continued implementation and it was evident, that with the exception of the documentation, the unit would return to their previous ways of working.

In contrast, unit 2 demonstrated huge potential for growth in all directions. There was a rootedness and embeddedness of change in culture and practice. A systematic approach was taken where issues were discussed and there was joined up thinking about how to implement and sustain change. The views of staff and residents were included in this approach. The CNM on this unit was a facilitator of the change and guided the approaches taken, but did not design the actions, rather she enabled the staff and residents collaboratively develop action plans to implement. Everyone had equal standing and there was potential to grow and flourish.

Conclusion

The process of evaluation that occurred throughout the project, as part of the ongoing work-based learning activities, ensured that all the stakeholder involved had a voice in the process of change. This overarching evaluation ensured that the process of implementation, the changes that occurred and how that was facilitated were analysed with the intent of assessing their effectiveness. It also enabled comparison between each unit and highlighted differences and similarities. The evaluation highlighted approaches that worked and barriers that hindered the implementation of the framework. It was a valuable tool for the participants at time 1 as the results of both the documentary analysis and the overarching evaluation at this time point formed part of the work-based learning reflective practice sessions and highlighted areas of practice and culture where change needed to take place. It led to the development of the prompts to promote writing in a narrative way sheet. At time 2 the evaluation informed the effectiveness or otherwise of the overall implementation in both units. It also provided a comparison between the approaches taken on both units during the project.

Chapter 9 Discussion of findings

Introduction

This study took a narrative stance on the implementation of an organisational change using an action research approach. The aim of the study was to develop and evaluate a methodological framework for a narrative approach to practice development and person centred care in residential care settings. The framework was used as a tool to help staff identify existing culture and practices and as a guiding framework to develop narrative strategies to improve care. Both values and principles can be seen in story and can be articulated to others through the use of biography (Grant et al. 2012). Narrative as described in Chapters 3 & 4 can be seen as a form of action that is closely connected to forms of life. They can describe and illustrate all aspects of human livelihood and existence, are rooted in a life world ontology and are concerned with interpretative inquiry (Heikkinen et al 2012). By creating an awareness of the use of narrative in practice and its influence on contextual issues we can enable staff to develop meaningful actions and processes (Clandinin 2007). This study was concerned with enabling healthcare staff to understand the life-world of older adults and to operationalise person-centred care through the use of narrative. During the implementation and overall evaluation of the study, key outcomes emerged in relation to the findings as illustrated in Chapters 7 & 8. These will be discussed in this chapter along with the limitations of the study, and its implications for practice. The Framework of Narrative Practice will be critically examined and areas that require further exploration will be highlighted. As the overall approach used in this study was narrative, and because the aim was to utilise narrative in practice, the key outcomes from the implementation of this framework in practice are based on narrative knowing, being and doing and centred around the key outcomes of:

1. How people responded to change (Narrative being).
2. The development of shared understandings (Narrative knowing).
3. Intentional action (Narrative doing).

While these key themes have been identified, as in the Framework of Narrative Practice, there is some overlap between them and in the way they emerged in the study. In the framework it is not possible to ensure 'working in a storied way' without taking accounts of the three elements of narrative, being, knowing and doing

together. While I will discuss each key message separately by virtue of their interlinked nature there will be some overlap between elements discussed in each. Elements of narrative being that related to how people responded to change were shown in the findings as the way engagement occurred and opening of communicative spaces and the facilitated learning therein. The development of shared understandings was highlighted in knowing the self and others and the perceptions and reflections that occurred within that and in leadership style. Intentional action was manifest in communication and how meaning was created and maintained within that.

How People Respond to Change (Narrative being)

These areas centred around the way events happened or did not happen on the units and the interactions that took place between me the facilitator, the staff, and the residents. I will discuss the type of engagement that occurred, the way communicative spaces enabled the intrinsic knowledge of the staff come to the fore and the type of change that became embedded in practice as a result .

Engagement

Engagement and the way participants engage is seen as an important component of action research, narrative and practice development (Kent & McCormack 2011). Engagement on both units was actively facilitated initially by engaging with the CNMs in the development of the Framework of Narrative Practice. Both of the CNMs were active participants on the four focus groups that collaboratively conceptualised the Framework of Narrative Practice (Chapter 5). Secondly, engagement occurred with the wider staff through their involvement in the work-based learning days, and ongoing action research study (Chapter 7). This approach is similar to what Patton (2002) described as the involvement of those who are most affected by the outcome of research, giving a sense of ownership of the final product and an ability to design an outcome that is directly relevant and useable in their practice. In an effort to promote engagement, prior to the implementation of the framework in practice I met with both CNMs, and their cooperation was sought to co-facilitate the WBL days and to promote the AR study on site. This is an approach advocated by Walsh et al. (2005) who stated that it is essential for engagement to take place prior to any action taking place as failure to engage in the early stages of the initiative can make it difficult for emancipatory change to occur in the later

stages. This approach also moves the process from one that is facilitator led to one that is collaborative and self-motivated (Dewar & Sharp 2013). It was hoped that by involving the CNMs in this way they would provide support for and enable their teams critically reflect on their current practice and change their ways of working. This occurred in differing ways on both units and will be discussed below.

While engagement is seen as crucial to the AR process very little has been written about the difficulties of encouraging engagement within a PAR (Snoeren 2011). While trying to understand the type of engagement that occurred in my study I found it was necessary to look to the organisational culture literature to examine the way participants in this study responded to change (Herscovitch & Meyer 2002, O'Donnell & Boyle 2008, Machin et al. 2009). While it could be argued that a nursing home is different from most large organisations, it is still non-the-less an organisation, and there are similarities in the way people engage with and respond to change between both. The organisational culture literature describes responding to change and the way people engage in change as showing support for change and by a combination of emotional/affective, normative and continuance commitment to change (Machin et al. 2009). Emotional support for change is based on a belief that the change will be beneficial. Normative support is given because the individual feels obligated and under duress to do so. Continuance support is based on the belief that it would be costly to not provide support (Herscovitch & Meyer 2002). Involvement and engagement in change can range from resistance both active and passive, compliance, co-operation and championing (Herscovitch & Meyer 2002)(see box 2).

Box 2. Stages of Engagement in Change

Active resistance - demonstrating opposition in response to change by engaging in overt behaviours that are intended to ensure that change fails.

Passive resistance - demonstrating opposition in response to a change by engaging in covert or subtle behaviours aimed at preventing the success of the change.

Compliance - demonstrating minimum support for a change by going along with the change but doing so reluctantly.

Co-operation - demonstrating support for a change by exerting effort when it comes to the change, going along with the spirit of the change and being prepared to make modest sacrifices.

Championing - Demonstrating extreme enthusiasm for a change by going above and beyond what is formally required to ensure the success of the change and promoting the change to others.

(Herscovitch & Meyer 2002).

Critically reflecting on the way participants responded to change during the study, it was evident, from the findings, that both units demonstrated enthusiasm and a desire to be engaged and involved in the study at the outset. This was supported by the CNMs in their roles as co-facilitators. In line with emotional support (Herscovitch & Meyer 2002), they believed that change would be beneficial for both the residents and the staff. In an attempt to bolster emotional support, and co-operation for the change, the initial narrative practice and culture identification sessions were conceptualised to enable engagement and participation of all staff. This type of engagement is based solely on the belief that the support will benefit the participant, and enhance their participative and behavioural intent to support the change. However, this only accounts for the support that was given to the implementation of the Framework of Narrative Practice and does not take account of the emancipatory intent of the overall action research approach. This intent was to raise the collective consciousness of the participants, to enable them to explore existing issues or problems, and to achieve change and cultural transformation (Reason & Bradbury 2011). In an effort to develop emancipatory intent, both the CNMs and I used the WBL sessions to enable staff to critically look at their own practice and the existing workplace culture (Chapter 7). Both units participated fully in the work-based learning sessions, when they occurred. In both units the staff were very knowledgeable about the structure of the framework and how to operationalise it.

They demonstrated this by being able to explain the framework to colleagues and linked this in their images of the identified culture (Chapter 7). This showed that staff at the beginning of the implementation process exhibited both emotional support, a co-operation level of engagement (Herscovitch & Meyer 2002) and an emancipatory intent (Reason & Bradbury 2011). However, as the study progressed the staff on Unit 2 exhibited an inclusive and collaborative approach with the residents, in the way they engaged them in the gathering of information and in the implementation of the framework in practice. They were progressing towards championing and emancipatory action. By being judicious in eliciting the views of the residents through gathering of interviews and observing current practice, they also actively engaged with the residents when developing action plans. Hynes et al. (2012) described this as engagement with different voices, and acknowledgement of different worldviews. Staff on Unit 2 achieved this by including the residents and all staff in identifying the present culture, and in providing ideas and strategies for change. This indicates that staff on this unit demonstrated what Manley et al. (2013) described as developing a shared purpose and which is one of the founding principles of PD work (Manley 2004). This may have been because they also fully embraced the work-based learning activities, that occurred between programme days, and were supported and facilitated, by their CNM, to collaboratively develop action plans to address areas where improvement could occur (Chapter 7).

On Unit 1 there was a stop/start element to their engagement, programme days were rescheduled and cancelled at short notice at the beginning of the implementation. This prevented them from fully participating in both the work-based learning programme days and the activities that occurred between programme days. Their engagement in the project started at what Herscovitch & Meyer (2002) describe as a compliance level of engagement. As the sessions progressed there was a turnover of staff that meant that staff participation in the WBL days was ever-changing. Continuity of participants was limited to a few staff with others coming and going over the time of the study. Selden (2010) describes the effects of staff turnover on psychiatric mental health programmes as having a detrimental effect on the development of quality services. However, even with this turnover of staff when the WBL sessions took place, the unit demonstrated a co-operation level of engagement by attending the WBL sessions and taking part in the identification of culture activities on the programme days. Unfortunately, they did not take part fully

with the WBL activities, (interview and observations of practice) that were required between programme days and they developed their action plan with very limited input from the residents (Chapter 7).

Staff had identified that areas where communication could be improved were life story work, informal discussions and interactions between staff and residents. When they developed their action plan, however, they focused on the technical aspects of care i.e. handover sheets, medication communication sheets, bed lists and laundry lists and neglected these more interactive engaging approaches. There is no literature available on the effects of staff turnover on the implementation of an action research initiative. Literature on quality of care and staff turnover (Spillbury et al. 2011), does suggest there is a direct relationship between staffing and quality of care. It is clear from the findings of this study that staff turnover did impact on the way Unit 1 engaged with the AR. In today's ever-changing healthcare environment, staff turnover and its impact on implementation of action research initiatives, may need to be considered when designing future research studies, as ways of minimizing this impact should be considered at the outset.

The findings show the way each unit engaged in the programme days mimicked the way they engaged with the residents on their units. Unit 2 embraced the philosophy of the Framework of Narrative Practice, used it to engage with the residents, and encouraged their participation in all decisions and planning of activities that occurred there. On Unit 1, staff were knowledgeable about the framework but did not fully utilise it in their interactions with the residents, but rather in a limited one to one basis which did not allow for any collaboration or shared decision making. These levels of engagement are also closely aligned to what List (2006) describes as the ladder of participation. This ranges from step 1 - manipulative co-option, to step 6 - interactive co-learning and finally to step 7 - self mobilization and empowerment. Unit 1 displayed both participative compliance (step 4) and participative co-operation (step 5) and Unit 2 displayed interactive co-learning and self mobilization and empowerment (steps 6 & 7), over the course of the study. Thus by ensuring that they collaborated, included and participated with the residents during the AR Unit 2 demonstrated an emancipatory approach. Both staff and residents were empowered by being involved in shared decision making (Brucknall et al 2008). This is similar to step 7 self- mobilization, described by List (2006), as the production

of knowledge about the problem under consideration, enabling the participants to become autonomous practitioners even when the initiative comes to an end. In contrast Unit 1 did not collaborate in a meaningful way with the residents when developing their action plans. They exhibited compliance with the WBL programme days but did not engage fully with the activities between programme days. This led to participative co-operation with the study. Recognising the relevance of the Framework of Narrative Practice and being knowledgeable about both the pillars and the operational elements however, helped staff critically reflect on their practice. While they did not attain emancipation, they did changes in line with a more technical AR approach (Reason & Bradbury 2011). The way that engagement occurred on both units can be further explicated by looking at the way communicative spaces were facilitated.

Communicative Spaces

In AR, dialogue is 'intrinsically' involved in interpreting both experiences and events (Sumara & Carson 2001). Habermas (1984) theory of communicative action states, that people relate to each other through co-operative interpretation of experiences and in the way they understand them. Without shared understanding there can be no meaningful communication. AR and narrative inquiry is about eliciting that shared understanding through critical reflexivity on individuals experiences (Clandinin 2007, Bevan 2013). An approach that values narrative and allows it to be iterative allows for the interpretation and articulation of events (Wicks & Reason 2009). In the study, participants on the WBL days critically dialogued their perceptions of events and the way things happened in an effort to enable action to occur. By engaging with their reflections and creating dialogue around them communicative spaces were opened up, this enabled the intrinsic knowledge of the participants to come to the surface (Cardiff 2012). The narratives of staff were linked to events, and according to Fried et al (2000), these events represent the self or the way the self is portrayed to the world. Opening communicative spaces presented a forum for the staff to portray themselves and reflect their identities, It was envisaged that this self revelation would enable what Gaydos (2004) outlined as the formation of trusting relationships. By enabling the opening of communicative spaces, opportunities were created for people to have their voices heard. This approach worked in different ways on the two units. While this was facilitated in similar ways in both of the units, the CNM on Unit 1 displayed a more

directive facilitation style in her co-facilitation of the WBL days. It is possible that this hampered the input of the participants on this site. However, in action cycle 1, narrative practice and culture identification, staff on both units demonstrated both their own and the residents shared understandings of the way care was carried out. This is similar to Bevan's (2013) study where the opening of communicative spaces provided a place for young mothers and professionals to discuss perceptions and understandings that otherwise may have been lost. A communicative space can help uncover layers of meaning or understanding (Wicks & Reason 2009). This was demonstrated in the present study when staff were exposed to the cleaners frustration (Unit 2), that no-one removed the wet floor signs he put up until he came back to work the next day (Chapter 7). Having an open and safe communicative space enabled the cleaner to highlight this frustration and encouraged critical dialogue to take place between all the staff in an effort to come up with a plan that would suit both the staff and the environment (Chapter 7). This approach is similar to what Pimbert as cited in Wicks and Reason (2009 p.251) describes as:

'Safe communicative spaces are carefully thought-out environments of mutual support and empathy in which people, who might otherwise feel threatened by sharing their knowledge and experience with others, can feel free to express themselves.'

It is not always easy to develop shared interpretations. This was borne out in the present study in the way Unit 1 collaborated in the WBL sessions. They participated freely and openly in the early sessions but when issues of power and poor practice came to the fore they were unable to achieve agreement on what to do about this. They resorted to looking at the technical aspects of care. In contrast, Unit 2 freely discussed and identified common areas that needed to be acted upon. They collaboratively identified ways of working to improve identified shortcomings and improve quality of life for the residents (Chapter 7). This approach was similar to that described by Kemmis (2001) as a process of testing both the accuracy and moral appropriateness of communicative acts. It also helped staff identify and make sense of their own values and beliefs, which Habermas (1984) stated is essential for identifying a communities shared understanding. It is probable that the stop/start nature of the beginning of the implementation on Unit 1, staff turnover and the directive facilitation style of the CNM, did not allow the group to develop in a cohesive manner. This may have denied them the opportunity of growing a communicative space where they felt safe enough to challenge assertions.

It is important when opening communicative spaces to be aware of obstacles or problems that can get in the way (Wicks & Reason 2009). As the AR researcher and co-facilitator of the WBL sessions, my role was to invite the staff to participate in a way that acknowledged and included their life-world and experiences of working in the setting. This, according to Trede & Higgs (2009) is a principle task of an action researcher and one that can lead to the identification of the development of critical dialogue. My insider perspective assisted me in gaining access to the site and in setting up the WBL groups as I already knew the staff. However, my outsider role as the action researcher may have clouded my views and prevented me recognising that issues were arising in Unit 1. Looking critically at this, it is clear that being a novice action researcher and my priori knowledge of the pressures staff were under influenced my engagement and interaction with them in the early stages of the study. I acknowledged and made excuses for their non-engagement at the beginning. Opening a more critical dialogue about the reasons behind this may have been more helpful. It is evident from the findings that the use of creative methods at the start of the WBL days enabled a greater flow of discussion and encouraged participation. Enabling practitioners to engage in the use of creativity can bring their embodied knowing to the fore and encourage reflexivity (Horsfall & Titchen 2009). These methods were used sporadically throughout the programme days. On reflection a greater use of creative media may have encouraged and facilitated a more critical dialogue to emerge. It is also entirely possible that staff may have acted differently because of their prior knowledge of me. This is illustrated in both the field notes described in Chapter 7 and in my personal reflection as described in Chapter 10. Wicks and Reason (2009) have described this as attending to the unfolding of interpersonal needs. They further advocate that failure to meet these unfolding needs may lead to the group becoming overwhelmed and could lead to a group that is focused on task, rather than taking account of the life-world of the participants.

The Development of Shared Understanding (Narrative Knowing)

In this study the development of shared understanding was exhibited in the way staff took account of their knowledge of self and in their understanding of their knowledge of the identity of the residents. It was also manifest in the leadership styles in terms of power and organisational considerations.

Knowing Self and Others

The findings of my study show, that while staff had a superficial knowledge of the identity and selfhood of the residents, they failed to use this knowledge to engage with the residents feelings about loss of independence or abilities. The self is based on information that the person gathers about themselves, it contains both the truths and false claims people make about themselves (Baumeister 2011). It is also based on interpersonal relationships and the actions a person takes. In short, the self is defined by the relationships a person has with others over a period of time. These relationships define how the self is perceived and interacts with others in their social world. In the study, while staff acknowledged the self of the residents they paid little attention to knowing themselves, that is identifying how the way they are and act impacts on the care experience for the older adult. Self identity according to Horowitz (2012) contains both future expectations and core beliefs and values. It predicts how we will act in a given situation and interact within relationships.

While staff on both units worked with identifying the beliefs and values of the residents in relation to the existing culture, they did not incorporate their own beliefs and values into the identification of the culture. According to Frie (2011), our stories and narrative identity represents who we are and where we come from, in other words our values and beliefs. They are interwoven with those of others and our selfhood is situated and linked to the wider cultural context of community. It is therefore important to include the stories of all who live and work in a context in order to truly investigate that context. Further, in order to have a sense of who we are, we need to take account of how our narrative identity is influenced and shaped by the way we are and act with others. Understanding the inter-relatedness of stories can enable the creation and development of communal understandings (Frie 2011). At the start of the WBL sessions staff discussed and clarified their beliefs and assumptions about person-centredness, narrative and the current culture by creating images and collages that represented their understandings. This according to Manley et al. (2013) is an important component when identifying the direction being focused on and when developing a shared vision for change. Further, they believe this is necessary to enable teams support and challenge each other.

While not embracing this philosophy fully the staff on Unit 2 did look at identifying their beliefs and values in relation to the way they showed respect for one another,

however, they did this in a limited way. They looked at how they respected the roles each member of staff had on the unit and how showing respect and valuing each person's role would improve the existing culture. They also developed action plans to implement this approach. On Unit 1 the staff identified their beliefs and values about person-centredness and culture in a similar way, but mainly focused on issues related to residents and not on what person-centredness and narrative approaches meant to staff. Therefore, in the sense of integrating both the values and beliefs of the resident and those of the staff, this did not occur in a meaningful way within the study. Both units ultimately focused on the beliefs and values of the residents and utilised those when identifying the culture and developing and implementing the action plans. This did not affect the engagement of the staff on Unit 2. It is possible that if the beliefs and values of the staff on Unit 1 had been looked at in a more meaningful way and integrated into the actions, barriers would have been highlighted at an earlier stage. This may have enabled them taken a fuller part in the implementation. As a novice action researcher I failed to take account of the importance of this issue in the early stages of the study. It is also possible that the fragmented approach in Unit 1 and the desire of both units to focus on actions, led to rushing this important stage in favour of the development of plans to address change.

The culture in which a person exists shapes the self's identity and ultimate being. It is a basic human function to share knowledge within a system where roles are defined. This system, according to Braumeister (2011), is called culture, or in other words the process we as humans have for making sense of our lives. Culture depends on good communication and is connected to our occupations, status and where we see ourselves in our own society (McAdams 1995). On both units, staff did not appreciate the status of the residents as evidenced by the documentary analysis (Chapter 8). It is possible that the Framework of Narrative Practice's emphasis on taking account of past lifestyle, abilities and status made it difficult for staff to identify what they were looking for. It may be that staff needed more direction and guidance on how to identify residents' expectations of loss of control and this should also be considered in any future research.

The self is also made up of the narrative history of the person that allows them to both make sense of and analyse life events. The way the person acts in their

present life is organised by the way they interpret past events and by using that interpretation to identify future potentials and actions (Baumeister 2011). This interpretation of self is similar to Ricour's (1985) and Heidegger's (1962) conceptualisation of self as incorporating temporality, where life events come prior to the development of a narrative of self and where that narrative informs the way we take action. Several authors (Baumeister 2011, Horowitz 2012, de Munck 2013) hypothesise about the link between identity, self and culture. Identity has been described as the person's sense of sameness or being throughout time. Identity is who the self becomes once outside influences, such as culture, environment and experience, act upon it (Horowitz 2012). Self identity contains both future expectations and core beliefs and values (Horowitz 2012). It is this combination of complex ideals that predict how we will act in a given situation and how we will interact within relationships. People's narratives indicate how they might respond when faced with unexpected or unusual circumstances such as coming into care. Maintaining both Identity and self esteem is important for psychological and physical well-being, as they impact on social functioning and interaction. Using a narrative approach enables us to include missing dimensions of the self, those of time (temporality) and historical context (where we came from). Using narrative can inform relational thinking, and facilitate interaction and engagement within groups (de Munck 2013). It is important that the facilitator of AR is skilled at recognising the importance of this and also of enabling the therapeutic use of self and others (Freshwater 2002).

Leadership

Literature supports the importance of having a manager that is participative in order to foster change (Case & Marner 2014). This is characterised by a motivation to attain goals through their staff, rather than as an individual and to be seen as part of the team, rather than a critical observer (Lindeman et al. 2003). A facilitative leader increases the possibility that change will happen and will be sustainable. A key finding from a previous practice development study (McCormack et al. 2010) found that failure to involve the middle managers in the research process led to lack of ownership and willingness to engage or buy in to the practice change. In an effort to negate this effect, the CMNs on both units were invited to be co-facilitators in the WBL days (Chapter 7). They were also involved in the development and refining of the Framework of Narrative Practice (Chapter 5). Meetings were held with both

managers to outline their role and also prior to each programme day to jointly agree agendas and the roles both of us would take in the facilitation of the day. Both CNMs displayed very differing leadership styles. The CNM on Unit 1 had a directing/hierarchical transactional style and the CNM on Unit 2 had a facilitative transformational style (Huber 2013). A transactional leadership style is one where the leader is there to ensure compliance and is based on the nurse managers authority and staff adherence to rules and procedures. A transformational leader is one who values each staff member's opinion and who is able to facilitate interpersonal relationships and communication (El Amouri & O'Neill 2014).

Grant (2004) advocates having a strong goal orientated leader in order to bring about a change in culture. While this may be seen as a good idea it is important to ascertain what exactly the goal of the leader is at the outset to ensure it matches the goal of the proposed change. In this study it became evident that the goal of the manager on Unit 1, while matching the intent to promote person-centred narrative practice, did not match the emancipatory objective of enabling therapeutic relationships and promoting human flourishing. It is possible that this was due in part to the transactional style of leadership she displayed. While there is a vast body of literature on differing leadership styles and their effect on culture (Grant 2004, Bass et al 2005, Solman & FitzGerald 2008, Huber 2013, El Amouri, & O'Neill, 2014, Martin et al. 2014, Ross et al. 2014) there is no literature that provides guidance for novice facilitators on how to work with differing leadership styles within a PAR initiative. By failing to take account of the differing leadership styles at the early stages of the study, I did not recognise the effect this would have on sharing of power, a key component of PAR, which assumes the equal sharing of power between all participants (Reason & Bradbury 2011).

The situated focus theory of power purports that people who have power tend to focus on their own objectives, avoid distraction and ignore unrelated undertakings to the detriment of goals that they feel are unimportant (Guinote 2010). Positive and enabling leaders enhance the positive social cohesion of their group (Case & Maner 2014). The success of many groups depends on how well they work together - group cohesion can have affirmative effects on how the group acts (Case & Maner 2014). Facilitating group cohesion is one way an effective leader operates. They bring this about by facilitating and enabling good group communication. However,

leaders wishing to protect their own power or hierarchy suppress positive relationships and do not promote group cohesion. Both of these approaches were evident in the present study. The CNM on Unit 1 did not promote group cohesion, she decided what roles staff took on and gave direction rather than facilitation. She was also keen to supervise all aspects of the implementation. This led to staff apathy and passive engagement with the PAR. By contrast, the CNM on Unit 2 role modelled excitement for the project. She took a full part in the programme days and encouraged the involvement of all staff. She further assisted with the identification of action plans and listened and valued the contribution of the team promoting cohesion and communication.

It is possible that the CNM on Unit 1 was not prepared for the growing knowledge of the staff and felt threatened by their increasing insight. According to Mead & Maner (2012), followers who possess skills and knowledge pose a threat to a transactional leader. These followers earn the respect of the group and have the ability to challenge the power of the leader. Leaders in this position often preserve their power by using subtle forms of control (Maner & Mead 2010). Transactional leaders are often motivated by either a desire to have dominance over the group or to have respect and appreciation from the group. It is unclear which of these motivated the CNM on Unit 1, but according to Case & Maner (2014), a leader with either of these traits will sacrifice the success of the group for the need to preserve their own power.

Conversely, transformational leaders support the values and ideals of their followers (Ross & Gray 2006). A transformational leader gains the trust of their followers and establishes a sense of shared or common purpose. Kouzes & Posner (2006) describe five leadership practices that embody a transformational leader: enabling others to act, encouraging the heart, inspiring a shared vision, challenging the process and modelling the way. On Unit 2 the CNM exhibited these five approaches in the way she both engaged with the study and the way she facilitated the involvement of the staff.

- Enabling others to act - rather than take a directing controlling approach the CNM on Unit 2 worked collaboratively with the staff, shared her power and was able to let go in order to attain a common goal.
- Encouraging the heart - the unit as a whole facilitated by the CNM celebrated

victories and created a sense of community, both internally in the unit and in the hospital in general, by inviting others to also be involved in and recognise their successes.

- Inspiring a shared vision - the CNM inspired a shared vision by valuing the views of both the residents and staff and by encouraging staff to develop action plans that looked to the future.
- Challenging the process - the way the CNM challenged the process was by encouraging the staff to look at new ways of changing the current practice. She facilitated their growth by encouraging them to develop their own ideas for change based on their identification of the present culture.
- Modelling the way - the way the CNM acted with the team by encouraging the voices of others, recognising their ideas and encouraging their contributions, helped the staff to emulate these behaviours with the residents and with those they engaged with to progress their actions.

According to Ross et al. (2014 p. 202), "when leaders are getting extraordinary things done in organisations, they are emulating these five practices". There is a need when commencing a PAR project to ensure that managers have a good understanding of the principles of practice development. They need to maintain their role as the ward leader, while enabling others to develop skills of critical thinking and reflection. This is particularly difficult for managers whose leadership style is hierarchical in nature and who have a desire to be in control of every initiative and development. The best leadership style according to Bass et al (2005), is that which adapts to suit the group one is attempting to lead.

Intentional Action (Narrative Doing)

Intentional action is an approach to attain a desired goal and is based on the belief that this is the best way to accomplish that goal (Burks 2001). Several nurse theorists have identified intentional action as a key concept in nursing practice (Orem 1985, Roy 1988, King 1999). Intentional action is based on the beliefs and values of the agent (the person or persons involved in the action), the belief that they can effect change and that the environment (culture) will be altered by that change (Burks 2001). The Framework of Narrative Practice was conceptualised to provide a guidance for staff to take intentional action when working with older people

in residential care settings. In particular, its intent is to look at the narrative of the work or the culture, look at the narrative of the residents and the staff, and look at the narrative of the everyday care processes, with the aim of developing action that is intentional and creates meaning for the residents and the care staff. The implementation of the framework in the present study aimed to provide staff with a method of identifying concerns about current work practices and ways of working and as a guiding framework to develop strategies to improve care. Barrett et al (2005), identify the value of having a systematic approach to ensure success of practice development implementation. Williamson & Prosser (2002) posit that often people resist change because they do not understand the intent of the change or the implications this has for their practice. Looking critically at intentional action and narrative doing in the implementation of the framework, it is possible that the intent of the change 'the implementation of a Framework of Narrative Practice' was seen differently by myself and the research sites. My focus on a collaborative, inclusive approach did not match with the managers approach of being the leaders of change on their units and on Unit 1 led to resistance to change and a focus on technical aspects of care. The manager on Unit 2 was willing to embrace the philosophy of a practice development approach and worked collaboratively with me in developing the programme days and in the ongoing implementation on her unit. While I made efforts to engage the manager on Unit 1 in a more proactive way, by having extra meetings to discuss issues and concerns when they arose, I nevertheless, did not fully understand the effect this resistance had on the overall study on that unit.

Narrative holds a unique role in categorising and managing knowledge of self. We learn about ourselves and others through the stories we tell and make decisions based on that information (Randall et al. 2006). Our lived experiences and our personhood within our social environment is inherently important in maintaining and providing meaning within the context of the intentional actions we take (Popova 2014). According to Popova (2014), intentionality is a process of interaction between agents, and it is through this interaction that we ultimately define who we are. In the Framework of Narrative Practice the operational elements, narrative being, narrative knowing and narrative doing provided a structure for staff, to help them integrate the personal narrative of the resident with the narrative of their existing circumstances and environment. The intent was to enable a more comprehensive understanding of the actions and responses of the resident to

change and in turn enable staff to act intentionally by providing care that is based on this understanding.

Staff undertook the WBL activities of observation, interviewing and reflection to enable them gain an understanding of the lived experiences of the residents and subsequently developed action plans to address areas of identified need. In my study, both units went some way towards accomplishing this goal, with Unit 2 developing more comprehensive actions than Unit 1. While these actions addressed some of the questions of intentional action, they fell short of ensuring that both internal factors and external factors were accounted for in the ensuing processes of care. Unit 2's actions took a more comprehensive account of the stories of residents and of their expectations of care. Staff used this feedback when developing their action plans. Unit 1 took an approach that was focused on safety and that did not acknowledge feedback received from residents, but rather privileged their own views of the existing culture (Chapter 7). This may have been because the framework itself was not specific in the identification of the influence of feedback and how that can alter the intended goal (Burks 2001).

Intentional action is also concerned with the process of communication (Kihlstrom & Isreal 2002). Communication in intentional action is an attempt at meaning making, where the listener strives to make sense of the verbal expressions of the teller. Narrative goes beyond merely telling a story, it includes the reason for telling that story and the way that story is understood. In narrative communication there is a reciprocity between the intent of the story and understanding or making sense of the story (Popova 2014). The Framework of Narrative Practice uses narrative being, narrative knowing and narrative doing with the intention of enabling staff to work in a storied way. It draws on the premise that stories are interactive processes that enable participatory sense-making between narrators and listeners leading to meaningful action. It is through this understanding that communicative action takes place. The act of communicative action is what Habermas (1984) refers to as mutually judging and understanding narrative expressions. The framework promotes the use of communicative spaces in order to promote critical reflection and collaborative action as discussed in the section on communicative spaces. However, this communication happened in a haphazard way and to varying degrees of success on both units. The framework, as utilised in the present study, identifies

meaningful two way and three way communication as important for an narrative approach. What the framework does not specify is what type of communication should occur and also whether this should include active listening. Facilitating safe communicative spaces and enabling critical reflection that incorporates active listening will be considered when reframing the framework in future research.

Limitations of the Study

The Framework of Narrative Practice is a methodological framework that is based on philosophical principles and theories of narrative (Labov 1997), person-centred care (McCormack & McCance 2010) and practice development (Manley & McCormack 2004). Conceptual frameworks have been described as guides for the development of practice (Robson 2002), however, according to Parahoo (2006) frameworks can also be used as an evaluation tool to analyse that practice. Lo-Biondo-Wood & Haber (2014) advise that a framework should bring together the research question, literature review and purpose of the study in a way that mutually complement each other. In the present study the framework was used to inform the purpose of the study, guide the practice of the healthcare workers through identification of their present culture and practice and development of action plans, and in the ongoing evaluation of the implementation of the framework in practice. In its present conceptualisation, the framework is not explicit in the identification of what quality of life means to the resident and also in describing how to identify and work with staff and resident self knowledge. While the framework as conceptualised worked with varying degrees of success on both units, critical dialogue with the findings and the literature has identified that a deeper insight into both contextual process and operational elements, needs to be taken account of to make the framework more meaningful and generalisable. Failure to take account of this may have been a limitation of the present study. Further the area of leadership and leadership styles is not explicit in the framework. The importance of this attribute cannot be overemphasised as the leader has the power to both assist or hinder the implementation of initiatives within practice settings. Failure to identify leadership style at the beginning of this study could have impacted on the overall outcome in both units. It is therefore necessary to consider this as a limitation of the present study.

Implications for Practice

The Framework of Narrative Practice was conceptualised with the intention of using narrative to assist healthcare staff with the operationalisation of person-centred practice. Narrative has not been used in this way before. Previously, narrative approaches have focused on either using stories to describe patient experiences or as a method of reminiscence therapy. The intent of this framework is to provide care that is person-centred and individualistic. In practical terms, the framework outlines an approach that provides staff with a template to enable them to make sense of narrative experiences and to use that knowledge in the provision of person-centred care. While the framework has been developed in older adult care settings, it can be applied to any care setting where person-centred approaches are valued. Finally, it is not intended that the framework be prescriptive, but that staff use it to critically examine how person-centred care is realised. By doing so, they can develop new ways of working that value biography and promote the development of a co-constructed plan of care that supports interaction and acknowledges the importance of life experience.

Implications for Further Research

The study has developed a new framework that is based on using narrative and narrative experiences to assess, plan, develop and implement person-centred care. The framework offers an interrelatedness between epistemological and ontological interpretations of narrative and a new method of developing knowledge. The theoretical foundations of the study and the methodology utilised enable a hermeneutic meaningfulness to be manifest, that provides a congruence between the aspirational intent of the framework and the tangible aspects of the practice culture. It would be interesting to study this framework in both similar and other practice settings to determine if the framework has generalisability and whether further refining of the framework would provide a deeper understanding of both the foundational and operational elements.

Furthermore, the effect of the leader and leadership style on the implementation of the study is of particular interest. Reconceptualising the framework to incorporate processes that include an initial approach of identifying and working with the leadership style, of the manager in the practice setting, would be worthy of investigation. One approach would be at the early stages of the project to

incorporate such an investigation into the identification of the practice culture. Data gathered could be used to develop ways of working that would take account of the influence of the leader.

Dissemination

Dissemination occurred both internally to the units where the study took place and externally through publication. The study findings and implications for practice were fed back to both units separately at sessions organised after the study was completed and the findings were written up. A summary of the findings and implications for practice were presented in the form of a power-point presentation and the participants were encouraged to take part in a question and answer session afterwards. A copy of this study was presented to the hospital library so all staff who wished to read it could have access to it.

External dissemination was achieved by publication of the development of the framework in the Journal of Clinical Nursing (Appendix 13). The findings and overall study key learning were published in two book chapters (McCormack & Buckley 2014, Buckley in press). Both the development of the framework and the overall findings have been presented at several conferences listed below:

- Delivering Health & Care Services For An Ageing Population Conference 2014. June 12th 2014
- Enhancing Practice 12 Conference Sydney. November 16th 2012.
- Knowledge Utilization Conference 12 Conference Melbourne. November 17th 2012.
- Constructing narratives of Continuity and Change Canterbury Christchurch University, May 12th 2012.
- Action Research 3 day workshop Stavanger University Norway, Dec. 17th 2011.

Future plans for dissemination include the publication of papers on both the documentary analysis and the overall research findings. As narrative and narrative approaches to care form a significant part of the national standards for residential care settings for older people, I further plan to engage with HIQA and present the findings of this study to them in an effort to engage on a national level with a view to influencing policy.

Conclusion and Contribution to Knowledge

The discussion demonstrated how people responded to change, the development of shared understandings and intentional action are interrelated and interlinked. It illustrates the importance of ensuring that practice context is taken account of in the implementation of action research and the importance of ensuring that narrative being, knowing and doing are clear and understandable for change to occur. Areas identified were engagement, communicative space, knowing self and others, leadership, communication and intentional action. The discussion highlighted the importance of being aware of barriers that may occur in the implementation of an AR study and the importance of having strategies to address these issues when they arise.

The importance of creating and opening communicative spaces was highlighted as an important area for consideration within an action research approach. Communicative spaces can help action researchers uncover layers of meaning and understanding that otherwise may be hidden.

The role and style of the leader was a further feature identified as key to implementation. Differing approaches by the leaders had differing effects on the participants. One approach that of transformational leader facilitating growth and the other approach that of transactional leader hindering and suppressing growth within participants. This in turn enabled or hindered the implementation of culture change within the units. The benefits of defining the leadership style of the manager prior to the implementation of a change initiative needs further research. This study shows that knowing the leadership style a leader exhibits and how that style may be worked with prior to implementing a change initiative is an important consideration when taking a PAR approach.. This knowledge would ensure the best possible approach is taken to the implementation.

As highlighted in both the limitations and further research sections, the framework in its present conceptualisation may require further refinement to address some of the issues identified in the study. It is hoped that in the future further research will be undertaken to develop and enhance the framework and that this will offer assistance to staff, who wish to develop narrative approaches to care, across differing healthcare settings.

Chapter 10 A Personal Story of Self Reflection on the Research Process: Bringing it all together.

Introduction

This chapter will look at my reflections as the researcher on both the research process and insights gained both professionally and personally during the course of this study. Because the study has focused on narrative and narrative approaches I have decided to address this chapter in a narrative way. The chapter will be undertaken using a reflective stream of consciousness narrative approach in line with the intent of the study. The reflection will be interspersed with excerpts from my own personal journal, which was maintained throughout the study, to illustrate points of interest.

Starting out on this journey of narrative, action research and reflection presented me with both an opportunity and a challenge. The opportunity to develop a workable model that may in some way assist staff to improve the care they provide for older adults in residential care settings and what I thought would be the challenge of doing that within the confines of a PhD study. However, while doing action research as part of a time-specific study is challenging, a far greater challenge, for me, was the unsettling reality of reflective self-identity and the need to be authentic within a cultural context. Several researchers have identified that change in self-identity can occur due to development or ageing or in response to some major life crisis or change in life role (Manzi et al 2010, Thomas et al 2014,). It is true that novice researchers undertaking a PhD thesis are undertaking a process of change, both self-change and professional change. What is also true is that change is difficult and often disruptive. As a novice researcher, I had not anticipated this disruption, both to my self-identity and to my psyche. I had also not anticipated the challenges that would occur in the study due to this disruption within others.

And so the journey began. Undertaking the study I had high hopes and a set of preconceived ideals. I was excited to be looking at the culture and being involved in a change process. Along the way I hoped to influence the growth and development of staff. I was aware that it would not be an easy process, but I had aspirations and an idea of how to gain both staff participation and involvement. While both units approached the framework in different ways, they did, never the less, embrace and

utilise it. What was a struggle both for me personally and for the staff involved during the implementation phase was the need to be reflexive and to use that reflection both to change practice but also to change our own preconceived ideas and ways of working.

The process of reflecting is one that is said to help both researchers and practitioners define and explore issues that arise in their work (Taylor 2002). It can be used to critically examine things that are going badly or to look at things that are going well and to see how that happened and what can be done to continue the trend. Reflective practice is finding a way through what Schon (1983) refers to as the swampy lowlands, cutting through the fog of uncertainty and fear to emerge at a place of clarity and understanding (Thompson & Pascal 2011). This is assisted by how we place ourselves in the world or according to Heidegger (1962) being-in-the-world. Our being in the world therefore influences our understanding of the situation, and it is also shaped by how others involved perceive the event. Johns (2005) describes reflection as a way of reinforcing our sense of self and reflective practice, as defending the knowledge we possess of our self and our experiences. While Johns believes that a certain amount of anxiety is useful in reflective practice he considers too much fear as detrimental to both the person and the reflection. However, several theorists believe we have an urge as humans to become more than we are, to be more than the self we start with to become a more embodied self, one that will allow us to grow and flourish. I believe that rather than reinforcing our sense of self, for many, the process of reflection can cause the person to lose the self, that is, become someone they had not intended to be. So in order for me to enable others to reflect, it was necessary for me to firstly consider and reflect on both my own self and my identity as a researcher and a person. This self-reflection enabled me to look critically at the engagement of staff in a new light, one where I could understand the reasons for some of the challenges that arose in the study, but also where I was able to stand back and realise that the way things were happening was because of the need for staff on some level to protect their own self-identity.

So here I am, and who am I? Which self am I at this moment, the student, the friend, the mother, the teacher in some sense, and wife. I feel I am being pulled in so many directions and now here is another one, one where I have to give of myself and where I am not sure I will get anything back. I was not aware that this would cause me this much inner turmoil, was not aware that I would be required to be this open and authentic, and certainly did not realise that I would be learning more possibly than I needed to know

about me. I would have run a mile – I think. Probably not - because I don't think I would have believed it. This must be what Giddens (1991 p.80) was referring to when he said that "such a situation leads to an unembodied self", one where the individual (me) is "continually acting out most or all routines". I really do not want to be acting out routines but I am feeling under real pressure over this. I feel torn between my need to remain private and the need for me to be authentic. Is it possible to be authentic and still keep something back – I don't know. So I suppose for me doing this reflection is about breaking down the barriers, both my own self controlling imposed ones and the ones that are imposed by the fear of others critique. I need to see this as a way of expanding my horizons rather than maintaining a rigid sense of identity where I am limiting my growth and learning. The important thing is to ensure that this change in self is managed in a way that protects my "ontological security" while preventing a descent into chaos and turbulence. This is about recognising that while I may be fearful of this change to stay the same would also be detrimental, not growing and maintaining a rigid approach to reflection would probably protect the self that is afraid but it would stifle the self that wants to expand my horizons. This is a challenge I think I must accept if I aspire to a set of values and beliefs, ones where I want to be a good role model and facilitate others to change. How can I ask others to be authentic and reflect on their practice, if I cannot facilitate myself to be authentic and reflect. Therefore, I intend taking the "bull by the horns", I don't think it will be easy or pretty, in fact I think it will be quiet messy and bloody hard. I will try to reflect in a way that is authentic and true to the values and beliefs I aspire to, but in some way will try to maintain a sense of security where I will not feel too exposed (not sure yet how I will manage this). I need to be mindful of doing this with others also.

Personal reflection 05/06/12

This reflection helped me recognise that if I felt worried about my ontological security perhaps staff also felt this way. In fact, due to the situations they found themselves in, that they may have a more valid reason for fearing for their psychological safety (Brown & McCormack 2011). When issues of passive engagement occurred on Unit 1, I was able to recognise the influences that caused these challenges but also able to realise that the staff needed to act in this way and to rush in and try to change it would be detrimental to their psychological well-being. It also helped me to realise that the level of engagement did in fact achieve an outcome for both the staff and residents. While it was not the outcome anticipated at the beginning of the study, it was nevertheless, a change from the way things were being done to a more person-centred way of working.

It is important to be aware of challenges that occur when implementing an action research study. Discussing and highlighting this I believe is both authentic and necessary. The action research literature is sparse on the impact these challenges have in practice settings and also on the need for some settings to take a longer slower approach than others. The need for flexibility on the part of the facilitator and willingness to change the approach is often not adequately reflected on in the literature, particularly when attempting to implement the same action research study across settings.

In an effort to help me understand what may have contributed to both the challenges of engagement, leadership influence and power imbalance, I have used evoke cards to try to decipher both my feelings and also what I think was happening on Unit 1. Evoke Cards¹ are a set of 64 cards that contain images that can help to evoke a range of memories, reflections or ideas.



I feel old practices are still taking place here and while there is some movement forward there is always a return to the familiar. I also feel that there is definitely a feeling here that there is only one way to do things and that is the way of the CNM. For me the whole thing has been very much a stop/start effort. Initially it was very difficult to gain any ground but as the project progressed it appeared we had at least got a yellow light where we could

¹ Evoke cards available at: <http://www.evokecards.com/index.html>

make some move forward. This did lead to some positive changes that did impact on practice albeit technical practice but change and movement none the less. However, this yellow light was still influenced by the dominant red light that eventually overwhelmed the weaker yellow and shifted everything back to the old familiar. I feel there are some rays of light/hope that struggle to shine through the dark clouds but these are restrained and controlled by chains of power. There is a huge power imbalance in the unit and a very hierarchical structure.

I am finding it difficult to see what I have learned from this. Much like the sun trying to break through the dark clouds I am struggling to see the light either in the practice or in my feelings about the implementation of the study. I find myself drawn in particular to the chain and the image of the links they are very rusty which implies they are old or overused, I find myself thinking of the old ways of working and how the chains represent this. The links also remind me of the way everything is interlinked here and how the rust (attitude) can spread so easily from one link to the other because they are linked. But the rust also implies weakness and the possibility that the links can be broken. Maybe this is showing me there is hope or opportunity for change or at least to break out of the binds or restrictions that are stopping this happening. I am frustrated by the one way/only way card this is not a value I espouse or one that I thought the unit espoused (from values work done early in project). I want there to be lots of ways with lots of ideas that are critically discussed and thought through, that acknowledge everyone's contribution and focus on the care experience of the older adults living here and not primarily on the difficulties of the staff which is what seems to be currently happening. Both the chain and the one way card are highlighting to me the inability of the staff to speak up. I am thinking of Brown & McCormack's (2011) work on psychologically unsafe environments, and how the influence of the CNM may be preventing the staff speaking up or indeed taking control of the way practice is occurring. I am concerned that the staff appear to lack a voice in this setting.

I think I have learned it is difficult to implement change when someone with power is preventing that happening. I think I learned that people will smile to your face but sabotage you behind your back. (maybe I knew all of this before I just had not considered that it would happen). I think the main thing I learned is that leadership is key and if the person who is leading is not willing or not able to encourage staff engagement in a participative rather than controlling way this will impact negatively. I think I must also take some learning for the way I engaged with the CNM. While I accepted her reassurances that she was practicing and encouraging the WBL activities as we agreed, I was aware that this was not always happening. While I did challenge this on occasion I may not have challenged enough. I know that facilitation is a balancing act and that getting the balance right is very important. In my efforts to maintain the balance between participation and non engagement I may have intentionally overlooked some early signs of power dominance. This may have been a failing on my part. I need to critically look at my facilitative skills to see if there is something that I could have done differently that could have helped or prevented this occurring.

Personal reflection 26/4/14

It is important as a facilitator of PAR to not only look at contextual issues but also to look at issues of personality and leadership. An authentic facilitator needs to be aware of their own self-identity, the identity of the practice setting and the identity of those involved in the PAR. Our identities are shaped by our experiences, these in some way shape the way we are or act. Being aware of and working with the relationship that exists between identity, leadership and power at the outset could help minimise challenges to implementation. If I had worked with the leader on identifying her leadership style and used some of the positives of that style throughout the study it may have enabled a better outcome. If I am being truly critical, I think I tried to change her leadership style to one I believed would enable action, rather than working with her existing style and finding the positives within that. Being aware of the support each setting needs at the outset of a study could have a positive influence on the outcomes.

My work role at the time the study was conducted was that of the practice development facilitator for the site. This gave me an unique perspective into the working and living conditions of the participants and provided certain insider advantages. Namely an ability to be empathetic to the difficulties of the participants and a rapport with them that made communication easy. However, it also put me under pressure to accommodate all the competing agendas that impacted on their engagement with the study. Since the study has been completed I have taken up a new role in a different facility. My role there also involves a practice development component. As the leader responsible for the clinical education of the staff and the development of evidence-based person-centred care within the home, I intend to introduce the Framework of Narrative Practice (FNP) to this new setting. I believe the findings and key learning from this study will enable me to be mindful of the particular concerns and barriers that arose and to address these with a better understanding. In my new role I am also responsible for outreach education to a number of different nursing homes in the greater Munster region. I have utilised the learning achieved in this study along with the FNP and integrated it into a number of the programmes that I develop and deliver, narrative documentation practices, responsive behaviours, and person-centred care to name a few.

I believe, as a novice researcher, it was not possible to be aware of all of the challenges that can happen within a PAR project as literature tends to focus mainly on the positive outcomes and rarely the challenges. However, where challenges have been identified it is not certain that being aware of them would have helped in this study. Challenges within PAR are context and person specific. Therefore, it is necessary for the facilitator to be adaptable, to work with challenges as they present themselves and to develop strategies that can help them work with these challenges and contexts.

Conclusion

This study contributes to the existing body of knowledge on PAR. It describes a framework based on narrative that can help healthcare staff to identify approaches that improves the quality of life of older adults in residential care settings. I believe that highlighting challenges and approaches needed when implementing a change initiative can assist other researchers undertaking PAR and PD.

This study has also been the story of both my personal and professional awakening. The study and my involvement with it has helped me to look critically at self and identity. This has led me to think about distinguishing being from knowing. If being is about interpreting experiences and communicating how does that affect knowing which is acknowledging humanity, reflecting on where we are in the here and now and sharing that understanding of ourselves with others. Are they mutually exclusive or are they working together to portray the real authentic me. To know the authentic me I need to be able to interpret the meaning of events, relationships and processes that make up my life as a whole.

I did not realise when I undertook this journey that it would be a process of self-discovery as well as a process of learning. I have seen a growth in my understanding of personhood and self and I have developed an understanding of narrative and its use in healthcare that I think can assist with developing new ways of working and approaches that value story and biography. My passion for research and the value of an action research approach in a practice setting has been further fuelled by my engagement in this study and the writing up of this thesis. I have also come to realise that answers only lead to further questions and that thes

new questions also need answers. The study has given me a further appreciation of the lived experience of being an older adult in a residential care setting. So in closing this chapter and this thesis, I would like to leave you with the poem I wrote during my study that also opened this study. To me it truly describes the lack of acknowledgement of biography, personhood and status that sometimes older adults experience in residential care face. It also highlights how we as carers through meaningful engagement using narrative approaches can change that change that experience to one of meaningful interaction and engagement.

Molly's Tale

This is my story
What does it mean
Do you care that I climbed mountains.
Or that I had dreams

to one day be famous,
an author or accountant.

You know me as Molly
A mother and a wife
but that is not the sum total of my life...
My dreams they were vast and some even came true.

This matters to me
Does it matter to you?

I sometimes feel angry
That you do not realise
I climbed Kilimanjaro when I was 35.
I wrote a novel in my 20s and I have 2 degrees.

This is the essence
of who it is to be me.

So I sit here in this nursing home
And my intellect declines
Because no one engages in a way that defines
The me I want to be, the person I am

The one with the accolades,
the parchments and bad hands.

Bad hands from working in a bakery
from sixteen to twenty four
but you didn't know that did you
as you come to my door.

You're pleasant enough
I cannot deny
But our conversation is superficial,
very American pie.

"Good day" "How are you"
"I hope you are well"
Do you really care...
I cannot tell.

I long for more substance,
to have a real voice.
To be considered in decisions
regarding my life.

I want to contribute,
I have some ideas
I was really quite something
before I came here.

So please do include me
and let me take part.
Ask my opinion
it will be a start

Debate and consensus
make everything clear
When you work in this way
it really shows that you care.

Catherine Buckley 2014 (c)

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Appendices

Appendix 1 Search Strategy

Database	Search Terms	Limits	Results
CINAHL	<p>Narrative “OR” story “OR” biography “OR” life history “OR” autobiography OR” Narratology “OR” narrative inquiry. (11,259)</p> <p>“AND”</p> <p>Elderly, older adult, aged, older people. (282,584)</p> <p>“AND”</p> <p>methodology “OR” method “OR” approach “OR” process “OR” technique. (217,643)</p> <p>“AND”</p> <p>health care “OR” residential care “OR” Long term care. (55,860)</p>	<p>All years- 31/10/2009</p>	<p>Total =253</p> <p>Excluded =200</p> <p>Included 53</p>
ISI Web Of Knowledge	<p>Narrative “OR” story “OR” biography “OR” life history “OR” autobiography OR” Narratology “OR” narrative inquiry (>100,000)</p> <p>“AND”</p> <p>Elderly, older adult, aged, older people. (>100,000).</p> <p>“AND”</p> <p>methodology “OR” method “OR” approach</p>	<p>Last 10 years: 01/01/1999- 31/10/2009</p>	<p>Total=125</p> <p>Excluded=100</p> <p>Included=25</p>

	<p>"OR" process "OR" technique (>100,000)</p> <p>"AND"</p> <p>health care "OR" residential care "OR" Long term care. (>73,914).</p>		
Pubmed	<p>Narrative "OR" story "OR" biography "OR" life history "OR" autobiography "OR" Narratology "OR" narrative inquiry</p> <p>"AND"</p> <p>Elderly, older adult, aged, older people.</p> <p>"AND"</p> <p>methodology "OR" method "OR" approach "OR" process "OR" technique</p> <p>"AND"</p> <p>health care "OR" residential care "OR" Long term care.</p>	<p>All years- 31/09/2009</p>	<p>Total=193</p> <p>Excluded=143</p> <p>Included=50</p>

Appendix 2 Letter Seeking Access to Site From Director of Nursing

7 Owenabue View,
Ballea Rd.,
Carrigaline
Co.Cork.



Dear [REDACTED],

I am currently a student of the PhD graduate school at University Ulster and a staff nurse working in practice development at St. Finbarrs Hospital. As part of my studies I am undertaking a research study titled “ The development and evaluation of a narrative based approach to practice development in an older adult residential care setting, utilizing residents stories to inform practice change” under the supervision of Prof. Brendan McCormack and Dr. Assumpta Ryan. The aim of this study is to develop and evaluate a methodological framework to extend a narrative based approach to practice development and person-centred care in residential aged care settings. It is hoped this research will enable nurses make sense of narrative experiences in the assessment, planning, delivery and evaluation of care and in turn improve the resident’s care.

I would like to apply for permission to undertake this project in St. Finbarrs Hospital. Participants will be chosen on the basis of fitting the inclusion criteria of the proposed study.

An information leaflet explaining the proposed study and a consent form will be provided to all participants. Consent to partake in focus discussion groups and audio recording of same will be obtained prior to commencing the study. I will ensure that the guidelines and code of professional conduct outlined by An Bord Altranais are adhered to. Participants will be allocated a number for data analysis and to ensure confidentiality will be maintained. Ethical approval has been sought and granted from the Clinical Research Ethics Committee of the Cork Teaching Hospitals.

I enclose a copy of the proposed research protocol. I would be grateful if you would consider my request and would be available at any time to meet with you to discuss same.

Yours sincerely,

Catherine Buckley.

Appendix 3 Letter Granting Access to Site.



NURSING ADMINISTRATION
Health Service Executive, South
St. Finbarr's Hospital, Douglas Rd., Cork
Ph: (021) 4966555, Fax: (021) 4966563

31st January 2011.

Ms. Catherine Buckley
A/CNM2 Practice Development Department
St. Finbarr's Hospital
Douglas Road
Cork

Dear Catherine

I write to acknowledge the proposal in respect of 'Implementing a Practice Development Framework using Residents Narratives'.

I confirm that the following will be available to you:

- Release of CNM grades to participate in education and participation as a part of their professional development.
- CNM agreement to facilitate work place learning groups.
- Full access to the residential site for this purpose and the understanding that consent from the residents to participate must be gained in advance.

Many thanks again

Yours sincerely



Appendix 4 Ethical Approval Cork Clinical Research Ethics Committee



Tel: + 353-21-490 1901
Fax: + 353-21-490 1919

Coláiste na hOllscoile Corcaigh, Éire
University College Cork, Ireland

COISTE EITICE UM THAIGHDE CLINICIÚIL
Clinical Research Ethics Committee

Lancaster Hall,
6 Little Hanover Street,
Cork,
Ireland.

Our Ref: ECM 4 (ggg) 08/12/09

24th November 2009

Professor Brendan McCormack
Professor of Nursing Research
Institute of Nursing Research
Room 17C19
School of Nursing
Jordanstown Campus
Shore Road
Newtownabbey
Co Antrim BT37 0QB

Re: The development and evaluation of a narrative based approach to practice development in an older adult residential care setting, utilising residents stories to inform practice change.

Dear Professor McCormack

Expedited approval is granted to carry out the above study in:

- St Finbarr's Hospital Cork.

The following documents were approved:

- Application Form
- Letter Seeking Authority from Director of Nursing
- Focus Group Information Leaflet
- Consent Form
- Letter Requesting Staff to Participate in Study.

We note that the co-investigator involved in this study will be:

- Catherine Buckley.

Yours sincerely

Dr Michael Hyland
Chairman
Clinical Research Ethics Committee
of the Cork Teaching Hospitals

Appendix 5 Ethical Approval University of Ulster



Shore Road
Newtownabbey
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BT37 0QB
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T: +44 (0)28 9036 6552/6518/6629
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www.ulster.ac.uk

Research Office

8 June 2010

Professor B McCormack
Institute of Nursing Research
17C19
Jordanstown Campus

Dear Professor McCormack

Research Ethics Committee Application Number: REC/10/0081

Title: The development and evaluation of a narrative based approach to practice development in an older adult residential care setting, utilising residents stories to inform practice change

With reference to the recent correspondence, I can confirm that the University of Ulster accepts the decision of the Research Ethics Committee at University College Cork and is content to allow the research to proceed. This is on the basis that all elements of the study will be unchanged.

Should any amendment be required, please contact the Research Governance Section for guidance.

Please complete and return the attached undertaking prior to commencing the research.

Please also note the additional documentation relating to research governance and indemnity matters.

Further details of the University's policy are available at www.ulster.ac.uk/research/rq along with guidance notes, procedures, terms of reference and forms.

If you need any further information or clarification of any points, please do not hesitate to contact me.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Nick Curry'.

Nick Curry
Senior Administrative Officer
Research Governance
028 9036 6629
n.curry@ulster.ac.uk

BELFAST ■ COLERAINE ■ JORDANSTOWN ■ MAGEE

Appendix 6 Information Leaflet for Residents

FOCUS GROUP INFORMATION LEAFLET

RESIDENTS

Title: The development and evaluation of a narrative based approach to practice development in an older adult residential care setting, utilizing residents stories to inform practice change.

Invitation Paragraph

The information in this leaflet tells you about a research study that is taking place in this hospital. You are being given this sheet because it is felt by staff that you may be willing to take part in a group with other residents that will discuss issues raised by the study. Whether or not you decide to take part is entirely your choice.

What is the purpose of the study.

The purpose of this study is to develop a method to help nurses who care for older people recognise the value of their life story and use information gathered from the life story to plan resident care.

Discussion Groups

You are being asked to take part in a group to discuss issues that have arisen in the study. This group will be similar to the residents forum group that you currently take part in and will be led by Catherine Buckley along with the Forum group leader. These sessions will be tape recorded if the group agrees or notes will be taken.

Do I have to take part?

It is entirely your choice whether or not you take part. You can say no. You can say yes at the start and then change your mind and say no. You may say yes, start with the discussion group and then feel like withdrawing. In all cases your decisions will be respected.

Should you decide to take part a date and time for this discussion group to take place will be agreed by the resident's forum group.

What will happen to me if I take part?

Immediately prior to the discussion group you will be asked to sign a consent form or give verbal consent that you agree to take part in the group. Meetings will take place approximately 6-8 weekly and last approximately 1 hour.

Will my taking part in this study be kept confidential?

The discussion group will take place in a private room and only the group members, the researcher and the forum leader will be present. After the meeting the discussion will be written up by the researcher. The discussion notes will not identify any group member by name and the notes will be anonymous. Any tape recordings made will be securely stored and only available to the researcher.

Are there risks or benefits to taking part?

The risks to yourself from taking part in this group discussion are very low. There is a possibility that you may feel uncomfortable knowing you are being recorded. In the

event you feel embarrassed or experience any distress then you can withdraw from the group at any time. Your privacy and dignity will be respected at all times. The name and number of the chief investigator is listed at the end of this leaflet and he can be contacted if you have a complaint about any aspect of the study. I cannot promise that this study will help you as an individual but it is hoped that the information obtained will help improve the quality of life and care of older people in the future.

The researcher's name is Catherine Buckley. If you would like any further information about this study please contact her and she will be happy to answer any questions you might have.

Contact details

Catherine Buckley
0876699416

Chief Investigator

Prof. Brendan McCormack

Appendix 7 Consent Form.

Title: The development and evaluation of a narrative based approach to practice development in an older adult residential care setting, utilizing residents stories to inform practice change.

Consent for Residents and Nurses taking part in Focus groups

I.....

Of.....

have read and understood the information leaflet describing the research project being undertaken by Catherine Buckley. I willingly give my consent to take part in the study. I understand that group discussions will be audio taped and my identity will not be revealed in any way. I will be assigned a code number for purposes of anonymity. I understand that my participation is voluntary and I have the right to withdraw from the study at any time and my care will not be affected in any way.

Signature of Participant.....

Signature of Researcher.....

Date.....

Appendix 8 Invitation to Staff to Partake in Study

7 Owenabue View,
Ballea Rd.,
Carrigaline,
Co. Cork

Dear Colleague,

I am currently a PhD candidate at the University of Ulster school of nursing and a staff nurse working in practice development at St. Finbarr's Hospital. As part of my studies I am conducting research under the supervision of Professor Brendan McCormack and Dr. Assumpta Ryan. The title of the study is "The development and evaluation of a narrative based approach to practice development in an older adult residential care setting, utilizing residents stories to inform practice change". The aim of this study is to develop and evaluate a methodological framework to extend a narrative based approach to practice development and person-centred care in residential aged care settings. It is hoped this research will enable nurses and other health care professionals' make sense of narrative experiences in the assessment, planning, delivery and evaluation of care and in turn improve the residents' care.

I would like to invite you to be part of a discussion group that will last approximately 30 minutes - 1 hour. All the information you provide for this study is confidential. Your name and details will not appear anywhere in the study. A code number will be used instead of your name. Discussion group tapes will be stored securely in a locked press and only be accessible to Catherine Buckley. Once the information is written up the tapes will be destroyed. If you agree to partake in the study please sign the enclosed consent form and return it to me at your convenience.

If you have any questions please do not hesitate to contact me. I enclose a copy of the proposed research protocol. I would be grateful if you would consider my request and would be available at any time to meet with you to discuss same.

Yours Sincerely

Catherine Buckley

Appendix 9 Staff Information Leaflet.

Title: The development and evaluation of a narrative based approach to practice development in an older adult residential care setting, utilizing residents stories to inform practice change.

Invitation Paragraph

You are being invited to take part in a research study. This study will form part of the researchers doctoral thesis. Before you decide whether or not to take part, it is important that you understand what the research is for and what you will be asked to do. Please read the following information. Do not hesitate to ask any questions about anything that might not be clear to you. If you would like an explanation about any aspect of the study please do not hesitate to contact me and please take your time to decide if you want to join the study. Thank you for taking the time to consider this invitation.

What is the purpose of the study?

This study aims to analyse residents stories, use that analysis to develop a new approach to interviewing residents and make improvements in practice for residents.

Focus Groups

This study includes discussion groups with nurses and residents. These groups will explore key issues of the study and the information obtained from these groups will be used to inform practice change. The groups will be facilitated by Catherine Buckley along with the ward manager. The key focus will be:

1. Looking at interviews to determine themes that may not be captured in the current interview process.
2. Identifying key components that are necessary for the development of a narrative based person centred framework.
3. Evaluating any change that occurs in practice.

These sessions will be tape recorded if the group agrees and/or notes will be taken.

Why have you been chosen?

You have been chosen because you are a registered nurse working in St. Finbarr's Hospital where this study is taking place.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep. You will also be asked to sign a consent form. If you choose to take part, you can change your mind at any time and withdraw from the study without giving a reason

What will happen to me if I take part?

If you agree to take part you will be asked to sign a consent form. (a copy is attached for you to review).

Catherine Buckley will meet with those of you who would like to take part to answer any questions you may have.

Meeting dates will be approximately 6-8 weekly for 1-3 hours.

The focus of each session will be agreed in advance.

Are there any possible benefits of taking part?

I cannot promise that this study will help you as an individual but it is hoped that the information obtained will help improve the quality of life and care of older people in the future.

What if something goes wrong?

It is unlikely that taking part in this study will cause any medical complications. If you decide to take part the name and telephone number of the chief investigator are listed below and you can contact him if you have a complaint about any aspect of this study.

Will my taking part in this study be kept confidential?

If you agree to take part in this study your name or any identifying characteristics will not appear in any reports of publications. Each participant will be allocated a code and all information associated with this study will be held securely and only accessed by Catherine Buckley.

What will happen to the results of the study?

It is hoped the results of this study will inform practice change that will have direct benefit on the quality of life of residents in long term care. The findings may be published in professional journals or presented at conferences.

What Staff can expect from the Researcher?

Nurses taking part in the study can expect that Catherine Buckley will be easily accessible and contactable to discuss any aspect of the study with them.

Who has reviewed this study?

Ethical approval for this study has been granted by the Clinical Research Ethics Committee of the Cork Teaching Hospitals and the University of Ulster Nursing Ethics Committee.

Contact Details

Researcher

Catherine Buckley can be contacted on 0876699416 if you require further information about this study.

Appendix 10 Examples of Interviews from National Person-centred Care Practice Development Programme.

Female Resident CR3

I can't stand fish. It's perfect - I couldn't ask for any more - plenty of food - nice bed - cleaning done for us.

Kitty and myself here are friends. I was at home working near Bons in Tralee. I fell on floor and broke hip - here since - a year ago. I was away in London for years childminding, in Aer Lingus, at St. Johns Wood Hospital - nurses aide - was lovely work - was hard - had to be up too early. They have an easier life here and there. They worked for nuns there. Work here is easier, much easier. Night nurses very kind and very good. Worked Aer Lingus Hotel Kingston hard job. Came back to Tralee 10 years ago - husband never liked London - always wanted to come here - bought house, he got job with Council, driving lorry until he had heart attack two years ago. My house is blocked up since I've been here - very sad. Saved all money to buy house. Hard job, fall and break hip.

Male Resident SFR1

It's a shock being geriatric when you were healthy up to this. Realise you are lucky as there are people much worse than you are. Disability is not your fault, before it happens to you, you may reject people with a disability. Didn't enjoy other room (patient was moved from one 6 bedded room to another) or C.U.H. as confused people there and felt threatened. Feel people talk more in this room.

When I was younger I liked travelling. Work gave me good opportunity for this. Enjoyed work as town planner. Enjoyed going on holidays with family.

I got the stroke on 1st June. I got great encouragement in C.U.H. and was surprised to come here so quickly. Generally a step in the right direction. It could be terminal here, problem of passing the time. I got the books and passed the time with them. I find it hard in the late evening. Spirits tend to go down in the evening. Playing cards helped a bit with this.

In the long term we are all dead. Have to go through the process. Everybody is very well trained here and that's very important. People have been very encouraging. I like the free and easy attitude of staff; they do not try to control the patients.

Dayroom is very depressing, no proper storage, mismatched furniture, looks like old people's home. I would like to see a better dayroom and nice garden.

Male Resident, BR5

I don't like being here I get on well with G. I get on well with all of them. I'd like to be at home G..... with K. my daughter

I gave them all a site. Had several farms one in Fermoy, one in Ballyporeen 3,500 sheep in Fermoy rented farm

The staff work hard - they do and they don't.

They come in to see you very often K and J (family)

Do you watch TV? Sometimes, the news. The staff don't mean nothing. Other patients are coming and going doing their own business. Chat with them now and then. The food is good. I don't like being in room on my own but try to make best of it. Would you prefer company? I would and I wouldn't. Would you like exercise? I would but it would be a waste of time

When I was working I used always have plenty of money. Many the person I gave a lone to. I gave --- £1,700 to build piggery - he has a son in university now. I had plenty money - money was scarce then but I worked hard for it. I was a great judge of sheep. Man gave £1,400 for them and he took them to factory. Had one horse, he was a cob, used him for pulling poles up the hill £1,700 from P&T to put up poles. Putting down pipe for cables sub-contractor for P&T I had nearly a hundred men working that time. I didn't spend hardly any I haven't too much of it now but I have enough. I nearly have everything I want. 'Tis nice enough in here.

My son has a young fella a boxer won gold medal in Germany. I didn't see him box. Look at my shoes I have a hole worn in them from wearing them in bed. Keep my feet warm. Maybe G. will buy a pair for me. Would be nice if son brought in a picture (of boxing). Was in Mitchelstown one time. Had sister married in Ballyporeen. My mother died in Ballyporeen she was living with my sister. Sister bought a pub in Ballyporeen. I was buying a pub in Mitchelstown myself but the sale fell through.

Appendix 11 Permission for Secondary Data Analysis



Appendix 12 Questions for focus group

Adapted from Creative Hermeneutic Data analysis (Boomer & McCormack 2010) and Questions for group discussion (Hsu & McCormack 2010)

1. Read the stories and form a general impression of the data.
2. What did you hear from the story?
3. How does this story make you feel?
4. Based on what you've heard and what you feel what part of the narrative resonates with you and why?
5. Create an image of your impression, capturing the essence of the data.
6. Using your image and the identified parts of the story outline common themes heard in each of the stories. (achieved by concept mapping with participants)

7. What does Person centred practice mean to you?
8. Can you explain how this happens in practice?
9. What aspects of practice do you think could become more Person centred ?
10. What is your experience of the use of life story or narrative in the assessment, planning implementation and evaluation of care? Explain.

ORIGINAL ARTICLE

Valuing narrative in the care of older people: a framework of narrative practice for older adult residential care settings

Catherine Buckley, Brendan McCormack and Assumpta Ryan

Aims and objectives. To report on the development of a framework of narrative practice, in residential care settings for older people.

Background. Residential care settings for older people provide care for people who are no longer able to live in their own home. To date, the impact and structure of nursing practice on care provision in these settings has proved difficult to conceptualise within a specific nursing theory framework.

Design. A hermeneutic approach incorporating narrative methods was used.

Methods. Forty-six narrative interviews with older people in residential care were secondary-analysed for key themes through a three-stage process: by the first author, four focus groups of 12 clinical nurse managers and two independent experts. Themes were also derived from a focus group of eight residents who explored person-centredness and narrative. Finally, the combined findings were used to derive a single set of themes.

Results. The secondary data analysis process led to the development of a framework of narrative practice for the care of older people in residential settings. The framework is influenced by narrative enquiry, person-centred practice and practice development. It has four pillars, prerequisites, care processes, care environment and narrative aspects of care. To operationalise the framework of narrative practice, three narrative elements, narrative knowing, narrative being and narrative doing, need to be considered. Working with the foundational pillars and the narrative elements would enable staff to 'work in a storied way' and provide person-centred outcomes and a narrative informed philosophy of care for older adults in residential care.

Conclusion. This framework provides nurses with a template that confirms the identity of the older person taking account of their biography.

Relevance to clinical practice. The framework outlines an approach that provides staff with a template on how to provide person-centred care in a narrative way.

Key words: biography, gerontology, hermeneutics, narrative, nursing, practice development, residential care

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What does this paper contribute to the wider global clinical community?

- This article provides a framework that identifies a set of pillars, prerequisites, care processes, care environment and narrative aspects of care to inform a narrative approach. It also outlines three operational elements, narrative being, narrative knowing and narrative doing, which will assist staff work in a storied way.
- Use of the framework of narrative practice will lead to ways of working that value biography and will help nurses develop co-constructed plans of care.
- The framework could be used to test a narrative approach to nursing care in residential services for older people.

Introduction

The impact and structure of nursing practice in the care of older people has proved difficult to conceptualise within a specific nursing theory (Nolan *et al.* 2004), and often these theories do not use narrative approaches when taking account of the perceptions of the older adult regarding expectations of care. Residential care residents are a unique group of individuals. They may not be acutely ill, but nonetheless need support through the ageing process (Kelly *et al.* 2005). For this reason, their values and beliefs need to be recognised when planning care. McCormack (2003) believes that nurses need to affirm the person that the patient is and that this can only be achieved by understanding the person's life as a whole. Paying attention to the concept of 'self' is critical to an authentic person-centred approach (McCormack 2004). While different conceptualisations of 'self' exist (Kelly 2010), Dewing (2008) argues that it is through the 'embodied self' that person-centredness is realised. The embodied self refers to ways in which a person's beliefs and values are manifested through their ways of being in the world. Recognition of the embodied self through respect for the person's biography allows others to know 'who I am' (McCormack & McCance 2010).

However, the use of narrative and the recognition of biography can lead to a co-constructed plan of care, which promotes interaction between residents and staff and acknowledges the importance of the life experience of the older adult (Clandinin & Connelly 2000). It can acknowledge personhood and identify issues that may pose problems for staff when caring for residents. To date, the gathering and usage of biographical information within residential care settings has been a haphazard affair. Nurse theorists acknowledge the value of this information, and other than suggesting the importance of biographical assessment, they fail to provide guidance on how to transfer such assessment into care planning and care practices (McKeown *et al.* 2006).

This article will outline the development of a framework of narrative practice to be used in the assessment, planning, implementation and evaluation of care in residential care settings for older people. Although the proposed framework is new and aims to guide staff, who wish to develop care through a narrative approach, it incorporates aspects of the person-centred nursing framework of McCormack and McCance (2010), and the relationship between the two frameworks will be clarified in the results section.

Background

Since the early 1990s, a wide range of research and practice development work has been undertaken in residential care that in some way takes account of the needs of older adults in an effort to improve the quality of care and promote well-being for the resident (Reed 2008a,b). Reed and Payton (1997) conducted a study to examine how older adults adapt when they move into care homes. The authors identified relationships and interaction with other residents as being important to the older adults interviewed. However, staff did not recognise or had limited awareness of the importance of these relationships. Similarly, Buckley and McCarthy (2009) hypothesised that services for older people should be shaped around maintaining connectedness and promoting integration of residents in residential care.

Findings from a Republic of Ireland's practice development programme (McCormack *et al.* 2010) identified aspects of care practices that negatively impacted on person-centredness and person-centred relationships. These included privacy, dignity, choice, power, hope/hopelessness, task orientation, environment, communication, interaction and teamwork. The study raised the importance of incorporating biography into care planning and of using this information to gain a clearer picture of how the beliefs and values of the person could be incorporated into care delivery.

The literature suggests that narrative and narrative method can address personal issues and social events and as such have multidisciplinary use (Phoenix *et al.* 2010). Narrative is the construction of an individual's life history and is a combination of all the significant events that occur in that individual's life (Squire 2008). Narratives have been used in health care to describe and give meaning to crisis events such as acute illness, cancer or debilitating illnesses such as motor neuron disease (Hayden & Orulv 2009). The advantages of narrative method have been well delineated with researchers promoting its use for the development of nurse-patient relationships, for understanding healing and empowerment of patients, for enhancing engagement and for enabling increased communication (Fredriksson & Eriksson 2001, Sakalys 2003, Carter 2010). However, the main use of narrative method in health care has been to elicit the reactions of patients or healthcare workers to a particular event or treatment option. To date, a narrative framework has not been developed that can be used in practice to assess plan and implement patient care.

Conceptual and theoretical underpinnings

The study is underpinned by theories of emancipatory practice development (Manley & McCormack 2004, McCormack *et al.* 2004), person-centred practice (McCormack & McCance 2006, 2010) and narrative method (Heidegger 1962, Polkinghorne 1988, Ricoeur 1991). Narrative in this study refers to both story and life. Consequently, the term 'narrative' is used interchangeably with biography, life story and life history. While narrative method is the overarching paradigm of this research, operationalising this approach also takes account of person-centred and practice development approaches. The concepts of person-centred practice currently expounded in the literature are derived from the Rogerian model of counselling, which is based on the assumption that each person is responsible for their own choices and decisions (Lane 2000) and that care is a mutual relationship between the patient and the carer, built on trust, understanding and respect (Binnie & Titchen 1999, Barker 2001, McCormack 2003, Nolan *et al.* 2004, McCormack & McCance 2010). There are many models of person-centred practice in existence, and recent studies have begun to explore their use (McCormack *et al.* 2010). However, the effectiveness of most of these models has not been fully tested, which may limit their application (Dewing 2004). The person-centred nursing framework (McCormack & McCance 2006, 2010) is one of the theoretical frameworks underpinning this study, and aspects of this framework were integrated into the framework of narrative practice. The person-centred nursing framework has been tested in practice initially in acute and more recently in residential care settings (McCormack & McCance 2006, McCormack *et al.* 2010, McCance *et al.* 2013), which has increased its validity. However, its relationship with

narrative and biography has not yet been determined. The present study seeks to develop a framework that contextualises person-centredness and facilitates the collection of narrative data.

Methods

Aim

The aim of the study was to develop a framework for a narrative-based approach to practice development and person-centred practice to be used with older people in residential care settings.

Research design

The study used a qualitative hermeneutic approach and consisted of two discrete data sets. The first data set comprised of interviews collected as part of a prior study (McCormack *et al.* 2010). These data were secondary-analysed, and the data collected during this analysis formed the basis of the second data set. These data were used to construct the framework of narrative practice Figure 1.

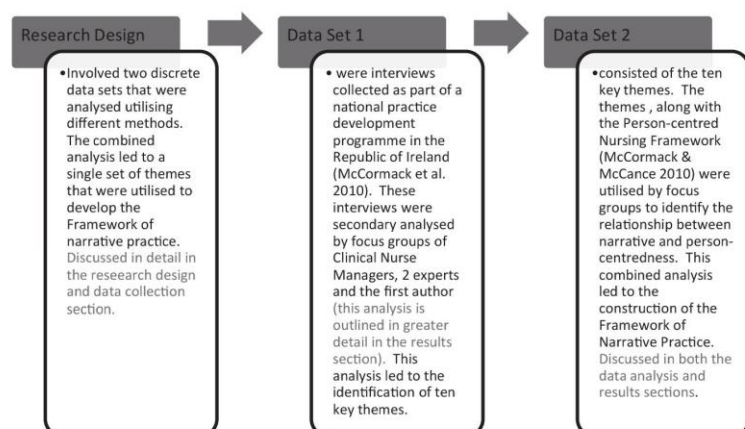
Participants and setting

Twelve clinical nurse managers and eight residents from a publically funded residential care facility in the Republic of Ireland participated in this study.

Ethical considerations

Ethical approval and permission to access the facility were granted by the local ethics committee and the residential

Figure 1 Research design and data collection process.



care setting where the study was conducted. Signed consents were obtained from both nurses and residents taking part, and all participants were informed that they could withdraw from the study at any time without the decision affecting either their care or their employment.

Data collection

According to Stewart *et al.* (2007), focus groups of between eight – 12 participants are ideal to promote interaction and discussion, and smaller or larger groups can either be dominated or are difficult to manage. For this study, a total of four separate focus groups, each one comprising the 12 nurse managers working at the participating site, were conducted. At these focus groups, the participants explored the concepts of person-centredness, narrative, considered narratives relevance to working with older people and how this would impact on the daily lives of older people in residential care. A focus group with eight residents was also held, where the first author and the residents explored what aspects of narrative were important for staff to know when planning care. The construction of the framework of narrative practice is based on the conceptual understanding that the nurse managers and residents had of what elements of narrative were important for high-quality care and good quality of life for residents in residential care settings. This conceptualisation was based in part on the theoretical underpinnings of the person-centred nursing framework (McCormack & McCance 2010) and on the findings from secondary data analysis of narratives from older adults in residential care. Interviews with 46 residents in residential care (collected in 2007–2009) during the Republic of Ireland's practice development programme (McCormack *et al.* 2010) were used by the focus groups to initiate discussion and identify themes that led to the development of the framework of narrative practice.

Data analysis

Data were analysed through four phases. Available evidence suggests that secondary data analysis can provide a more insightful interpretation of the primary data and may also aid in research design (Church 2002). Secondary data can be used to answer new research questions or indeed to challenge the original research findings. It ensures that the best possible use of the data is achieved, and it can lead to further understanding of the results obtained in the first study (Coyer & Gallo 2005). A major disadvantage of secondary analysis is that data collected for one study can impact on its usefulness in a second study (Smith 2008).

In the original research (the Republic of Ireland's practice development programme), the guiding question 'What is it like to be a resident here?' was used to obtain information on the lived experiences of older adults in residential care. In this study, secondary data analysis was conducted to further analyse the life of older adults in residential care, and it was therefore considered that the original data were congruent with the research aims and questions.

The first-phase analysis is based in part on Richmond's (2002) storymap and on Bluck and Habermas's (2000) life story schema. Richmond's storymap is influenced by the theories of Mishler (1986), Bruner (1987, 1990, 1994), and Clandinin and Connelly (2000). A schema is the organisation of past responses and past incidents (Bluck & Habermas 2000). Schemata are a mental organisation of a person's past that models their experience with life. Bluck and Habermas' (2000) theoretical model of schema is based on four tenets of coherence. They are temporal, causal (or structured event), thematic and biographical (cultural ideation). Schema theory emphasises the mental connections humans make between bits of information (Bluck & Habermas 2000).

The interview transcripts from the older people who participated in the original study outlined above were analysed by the first author, taking into consideration the hermeneutic relationship between life and story, under the influence of the storymap (Richmond 2002) and the life story schema (Bluck & Habermas 2000). Three copies of the data were made: a master copy, a complete copy used throughout the analysis and a copy used for coding. Transcripts were read twice to obtain an essence of the interviews and to become familiar with the language used in them. Interviews were then read to identify whether they adhered to the storymap, that is, had a beginning, middle and end, and also to ascertain that they adhered to elements of the life story schema (temporality, structured events, life themes, cultural ideation). Interviews that did not adhere to any of these elements were rejected.

A total of 46 interviews were read with six being excluded for not meeting the criteria for analysis. Interviews were reconceptualised to fit logically into the past, present, future or beginning, middle and end elements of the storymap by colour-coding passages of the interviews that fit into these elements. Interviews were then restructured to flow logically from beginning to end, by cutting and pasting the coded passages. This is what Bluck and Habermas (2000) refer to as 'linking elements of life with each other and with the present self' and is according to Lai (2010) important if researchers are to fully understand both the tacit and explicit information in a narrative. Clandinin (2007) believes there is no correct method of analysis, but the approach taken should suit the purpose of discussion. Therefore, it was considered appropriate to reorganise

the interviews, so that they could be clearly understood (Riessman 1986, 2000, Clandinin 2007, Hsu & McCormack 2011). Each data passage retained its resident code designation to help the researcher identify the original interview the data came from. These transcripts were read through several times, and text that appeared to describe important or repetitive comments was highlighted (Hosburgh 2003). These highlighted passages where given codes, and this is known as open coding and what Granheim and Lundman (2004) describe as ascribing a meaning unit to the text. These codes represented the words of the respondents and were freely generated. The codes were further reduced and focused into themes keeping codes with similar content together. This was done by cutting and pasting the codes onto a word document. Creating themes according to Coffey and Atkinson (1996) is a central feature of qualitative research, and as such, these groups of content must share a common thread or theme. These themes were further analysed by referring back to the original transcripts. A total of 12 themes were identified.

The second phase of analysis consisted of an analysis by the nurse managers who all work in services for older people. The nurse managers analysed the interviews using an adaptation of the creative hermeneutic data analysis framework developed by Boomer and McCormack (2010) and questions for group discussions (Hsu & McCormack 2011) (Table 1).

Following the steps of this framework, the managers independently read the interviews and identified what they heard and how the stories made them feel. They were then asked to make a creative expression of the part of the story that most resonated with them. Using what they heard and felt and the image of the identified part of the story that resonated with them, they were then asked to outline common themes in the stories. A total of 46 subthemes were identified. The group further discussed these themes and devised a new set of shared themes that acknowledged the relationship between the different identified subthemes. A total of 10 themes were identified (Table 2).

Table 1 Questions for focus group adapted from creative hermeneutic data analysis (Boomer & McCormack 2010) and questions for group discussion (Hsu & McCormack 2011)

Read the stories and form a general impression of the data
What did you hear from the story?
How does this story make you feel?
Based on what you have heard and what you feel what part of the narrative resonates with you and why?
Create an image of your impression, capturing the essence of the data
Using your image and the identified parts of the story outline common themes heard in each of the stories. (achieved through concept mapping with participants)

In the third phase, two independent experts analysed the interview transcripts, taking a similar approach as in the analysis undertaken by the first author. The independent

Table 2 Subthemes and themes identified by clinical nurse manager group

Identified subthemes	Themes
Not sure who is who	Resident expectations
What do I want	
Conflicting desires	
Hospital or hotel	
Mixed emotions	
Happy	Contentment/satisfaction
Anything I want I get	
I have got company	
Good memories	
Contentment	
I am lucky	Loneliness
Grieving	
Loneliness	
Loss	
Reminiscence	
Unrealistic expectations	Communication (Staff and residents)
Failure by staff and residents to discuss the fundamental issues	
Interactions with staff good and bad	
Low expectations ('I don't expect too much')	
Some people are treated badly but I am lucky	
Compromise	Inadequate care/lack of holistic, emotional care. Resignation/acceptance
Putting up with what they are given	
Resignation	
I think it will always be the same here	
Quite happy used to the place.	
Boredom	Boredom/lack of activities
Lack of activity	
Day-long sitting here doing nothing	
Time seems long here you know	
I do nothing all day.	
Institutionalisation	Environmental factors
No choice	
Task routine	
Less activity with family routine	
Lack/loss of identity	
Lack/loss of autonomy	Loss
Lost independence	
Do not like where I am	
Loss of individuality	
Frustration	
Tired/worn out	Coping/not coping
Denial	
I am a survivor.	
Relocation stress	
Depressed	

experts are researchers who have expertise in narrative method, person-centredness, practice development and gerontological nursing. They analysed the interviews and identified key themes using a thematic analysis approach. In total, the experts identified eleven themes.

The residents' focus group discussed aspects of narrative that they felt staff should take account of when planning their care. Through these discussions, they identified eight themes they felt were essential for good care planning.

So in summary, the first author identified 12 themes, the nursing focus group 10, the experts 11 and the residents eight. While there was a certain amount of overlap, the different groups used different words to describe the same aspect of care in the narrative. A comparative summary of these different analyses is presented in Table 3.

An agreement focus group was convened with the nurse managers where the themes identified were merged and agreement was reached on common words to describe them. Ten themes were identified that were related back to the subthemes and had been identified in the original narratives by the first author, experts, nurse managers and residents (Table 4).

Rigour

Data were subject to analysis as described earlier by a range of people from a number of different backgrounds – nursing, academia and residents. There was a high level of congruence between the themes identified. Additional rigour

was attained by returning this data to an agreement focus group consisting of the nurse managers and the researcher for further discussion and refinement. This refinement led to the final set of agreed themes.

Results

The 10 themes identified were loss, boredom, staff attitudes, expectations, coping/not coping, loneliness, communication, resignation/acceptance, environmental constraints and contentment. These themes formed the basis of the development of the framework of narrative practice as outlined below.

Using a participatory approach in workshops and focus groups, the first author along with the nurse managers next mapped the agreed analysis onto the person-centred nursing framework. The themes developed during the analysis were aligned with the constructs of the framework. This alignment proved a valuable step in assisting the participants with recognising the linkage between narrative and person-centredness and also enabled them to explore what aspects of narrative were missing from the original person-centred nursing framework. A detailed picture of the relationship between narrative and person-centredness emerged, and this led to the development of the framework of narrative practice.

The pictorial representation of this framework indicates how the elements of the framework of narrative practice

Table 3 Comparison of themes identified by the four groups

Clinical nurse managers	Researchers	Experts	Residents
Boredom/lack of activities	Being occupied/importance of activities/past interests	Boredom	
	Fear	Hobbies/interests/activities	
Coping/not coping	Maintaining control	Fear for the future	Feeling safe
	Hopeless/helplessness	Frustration	Need for privacy
Communication (Staff and residents)	Connectedness	Contact with family/friends/community/animals	Meaningful interaction with staff.
Loss	Dependence/independence	Having to rely on others for assistance	Independence
Inadequate care/lack of holistic, emotional care	Health/failing health	Views on unit/staff perceptions	Knowing the staff
Resignation/acceptance	Staff attitudes		
	Resignation	Need to relax/let go	
Loneliness	Lifestyle	Restricted living/rules regulations	
Environmental factors	Unfulfilled longing	Missing home	
Expectations	Status	Areas for improvement/environment	To be involved in decisions. Having a choice
Contentment/satisfaction		Contentment.	Knowing us/who we are.
	Hard Times		
	Lifes' work		
			Religion

Table 4 Agreed themes and relationship with subthemes derived from comparative themes and themes from resident's focus group

Theme	Related to
Boredom	Lack of activities
Coping/not coping	Fear, loss of control hopelessness and helplessness
Communication	Staff, residents, family and community, meaningful interaction with staff
Loss	Past status, past lifestyle, past abilities. Independence
Staff attitudes	Views on the unit positive and negative staff perceptions. Lack of holistic or emotional care
Resignation/acceptance	Letting go, being able to relax
Loneliness	Unfulfilled longing, missing home, grieving
Environmental constraints	Rules/regulations, restricted living, areas for improvement Lack of privacy
Expectations	Conflicting desires, knowing the staff and the staff knowing me. Choice, being involved in decisions, valuing religion
Contentment/satisfaction	Happy where I am, feeling safe

provide both a base upon which to build the framework and the relationships that need to be addressed between the different elements to 'work in a storied way'. The framework consists of two major components. The first component comprises the pillars of the framework, and the second component is the operational elements.

Pillars

The framework of narrative practice comprises four pillars: prerequisites, care environment, care processes (from the person-centred nursing framework) and narrative aspects of care (derived from focus groups). During the development of the framework, the nurse managers described these four constructs as pillars and believed they represented the foundational underpinnings of the framework. Because the research is underpinned by an emancipatory practice development philosophy, which values collaboration, inclusion and participation and purports that the validity of the data will be made by the community involved in the creation of the data, the researchers were conscious that the findings should represent the values of the participants involved in the analysis (Manley & McCormack 2004). Therefore, it was important to ensure that the words used by the nurse managers informed the constructs of the final framework.

Three of the pillars, *prerequisites*, *care environment* and *care processes*, have been described in detail elsewhere in the literature (McCormack & McCance 2006, 2010). Therefore, they will only be described briefly here in relation to how they are used in this framework. The focus of this article is on the narrative aspects of care pillar and the operational elements of the framework.

Prerequisites

These are the qualities ascribed to and based on the professional expertise of the nurse. 'Knowing self' according to Stickley and Freshwater (2002) is essential to developing caring relationships that are therapeutic. Additionally, Cook (2006) asserts that knowing self leads to the development of an honest open relationship with others. This opens up the potential for the development of a negotiated approach to patient care, which is a central theme in many models of person-centredness (Kitwood 1997, Barker 2001, Titchen 2001, Nolan *et al.* 2004, McCormack & McCance 2006).

The care environment

This pillar promotes person-centredness in an environment where culture change is promoted by facilitating transformational leadership, where practice is constantly being evaluated and where the organisation is willing to adapt according to the outcomes of that evaluation. This framework recognises that supportive organisational systems must be put in place to attain these changes (Wilson 2005). These include developing a culture where practitioners can learn from their work, having a high level of interaction between patients and organisational management and enabling practitioners to identify and resolve issues for themselves (McCormack *et al.* 2004).

Care processes

These account for emotional aspects of care. According to Bellack (1999) and Fuimano (2004), emotionally intelligent practitioners are more connected and authentic. This pillar promotes reflection and engagement, which in turn promote personhood. By reflecting on their own practice, nurses are able to assess their authenticity, and this provides a basis for engagement that recognises the individuality of the patient.

Narrative aspects of care

This is the pillar where the value of narrative and 'knowing' the person is explicated. According to McCormack and McCance (2010), when nurses have a true understanding of the biographical details and rich tapestry that make up a person's life, a reciprocal relationship that

enables the patient to attain their full capabilities can occur. By obtaining the life history of the patient, nurses can attach meaning to both their involvement with care and the decisions they make with regard to life or care choices. It also enables nurses to acknowledge that when certain medical or nursing decisions are not having the desired effect, it may be the result of biographical details they were not privy to. By obtaining and incorporating the biography of the patient into their care plan and using this information to aid with the assessment, planning, implementation and evaluation of care, nurses can obtain a clearer picture of how the patient would truly want their care delivered.

Operational elements of the framework

While the pillars represent the foundation of the framework, its operational elements are *narrative being*, *narrative knowing* and *narrative doing*. Further discussions about how this new framework could be implemented in practice using the question: 'In what way or ways would you implement this framework?', led to participants identifying that three elements of narrative needed to be considered. Participants felt that they needed to be aware and take account of the person in their past and present life and to know how they interpret experiences and that using this information would help them work in a way that acknowledged who the person was and is. The participants also felt that adhering to specific subelements under the three elements would enable person-centred narrative informed practice to occur. In identifying these subelements, participants considered both the information they had gathered from the interviews in stage 1 and what they considered would need to be done to address each element, in a person-centred way, along with linking this to narrative aspects of care. These three elements are interlinked, and to operationalise the framework, aspects from each of the elements need to be considered. Figure 2 shows this interlinkage in the way that each element melds and blends into the other. It is proposed that taking account of the pillars and the operational elements will enable staff to achieve a narrative informed philosophy of care.

Narrative being

Narrative being highlights the importance of paying attention to and interpreting events, taking account of what happened in the past, what is happening now and what might happen in the future. Heidegger suggests that if we want to understand the meaning of being, we have to interpret the

mode of existence of the entity (Taylor 1994). Essentially this means that we must not only focus on the existence of the person but also on the context in which that existence occurs (Mackay 2005); that is, we have to know how our being is linked to the way we exist in the world (Heidegger 1962). He believed that if we want to understand our experiences, we must first understand who we are as thinking beings. Interrogating our existence helps us to understand the meaning of our being or our selfhood. Existence as described by Heidegger is that of a bodily active agent who is open to and vulnerable in relation to the world and who exists in time and has minimal control of its morality. Ricoeur (1991) in his article on narrative identity describes being as the way in which we respond to change and how we act with others in a period of time. Narrative being is about interpreting the experiences of the resident by acknowledging that they are performative beings who like to communicate. The framework ensures that the residents' past and present community and family involvement along with their views of what constitutes a good quality of life are accounted for in their plan of care.

Narrative knowing

This element is not just about life story and knowing that element of the person. It is also about perception, recognition (of the person as a human being and what that signifies), reflections (on interactions and the way a person's life reflects the way they act or are) and shared understanding. Narrative knowing is about ensuring that the identity or the 'I' that is rooted in the past is accounted for in the present time and is allowed to shape and build the future story of the individual (Polkinghorne 1988). It is possible that residents on admission to residential care do not foresee a future, but everyone has one. Often residents of residential settings seek to deny their future by focusing on the past. This is a mechanism to protect the 'self' or the 'self-identity' as they know it. It is the role of the nurse in these settings not only to ensure that the 'I' is protected but also to enable the resident to cultivate a new story – one that includes their present living arrangements. Chinn and Kramer (2008) identify ways of knowing as 'ways of perceiving and understanding', and narrative knowing is a way of perceiving and understanding the story of the individual taking account of salient aspects of their present history, but at the same time ensuring their past life status is also acknowledged. In this section of the framework, the residents' expectations of care are captured along with their feelings about their admission and their views on safety and risk.

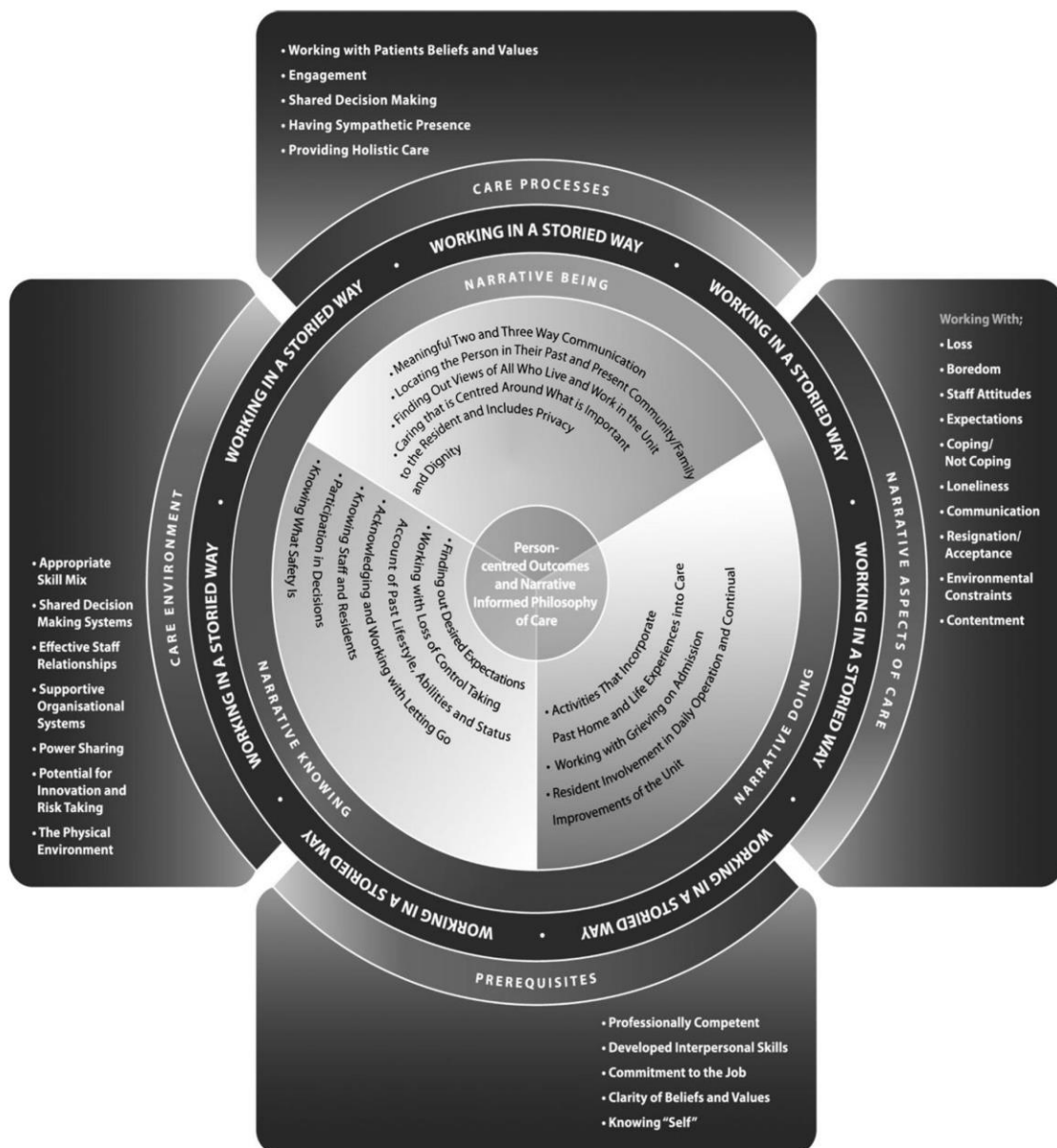


Figure 2 A framework of narrative practice.

Narrative doing

Narrative doing relates to intentional action. Creating and maintaining meaning is at the centre of all human activity (Andrews *et al.* 2004). Narrative doing is about ensuring that all activity is meaningful, has a purpose and provides an outcome for the participants. The outcome must have

relevance to the problem or issue the narrator wishes to address. 'Action implies goals' (Polkinghorne 1988), that is, they are undertaken with the intent of accomplishing something or achieving an outcome. Narrative is the means through which that action is understood and made meaningful.

Activity is defined as action. Action in this instance is concerned with ensuring that appropriate conduct takes place when issues are identified or outlined. Polkinghorne (1988, p. 135) states that 'the linguistic domain and the human order of meaning are organised according to hermeneutic rationality and aligned on various interactive levels'. Based on this, humans make decisions on what they want 'to do' to attend to these needs and wants. Our past stories and experiences provide us with templates for how we take action in the here and now and also for the way in which the outcomes of these actions are linked to the way we intend to take action in the future. Narrative is the vehicle through which action is expressed and understood. Narrative doing is based on reflection and action and can only occur if both narrative being and narrative knowing are also addressed. The framework ensures that actions based on the information provided by the resident or their families about their past life experiences, and also reflections on their current situation and their interactions with their present environment, are used with a narrative doing intention; that is, actions/activities engaged in and organised with the resident are based on a mutual interpretation of the hermeneutic meaningfulness ascribed by the resident to both everyday and unusual activities, that is, grieving, admission, living arrangements, etc.:

Action itself is the living narrative expression of a personal and social life. (Polkinghorne 1988, p. 145)

Discussion

Narratives in health care are often co-created (Clandinin & Connelly 2000). This means that the interactions that patients and nurses have can shape how the patient recounts their story. This process can be described as the art of nursing and can provide a therapeutic environment for patients where the person listening to the story is caring (Gaydos 2004). Narrative practice is 'also seen as part of a humanistic, person-centred approach' (Taylor 2003) that forms the basis of everyday nursing practice. Life story is about recording elements of a person's life and using that information to improve their present life (McKeown *et al.* 2006). The framework of narrative practice provides focus for working in a person-centred way and helps staff see a vibrant person, not an older dependent one. Knowing the person and their unique life history enables staff take account of what is relevant and of importance to the resident in their care experience. In assessment, the framework enables staff to identify particular needs, wants, likes and dislikes of the resident. Using the 'narrative knowing' section of the framework

enables the changing world of the resident, in relation to admission to residential care, to be taken account of when planning care (Chinn & Kramer 2008).

Using this framework will also allow staff to recognise the identity of the person and understand their family background and situation better, and it could also help staff form a common bond with the resident (McKeown *et al.* 2006). Older adults in residential settings want to make meaning of their life events, and this aspiration is often motivated by a desire to see a purpose to their life, or to be seen as important (Gaydos 2004). They may explain their current situation as a natural progression of their life; in other words, being in residential care was not their choice, but the next step in their life. Narratives, life stories and stories have all been used in nursing research to explicate lives and value human experience (Frid *et al.* 2000). They generally give practitioners an insight into how patients cope with illness or what the patients' journey through the healthcare system was like. The framework of narrative practice highlights the importance of acknowledging narrative as an important aspect of care planning and implementation. While the framework is based on and underpinned by the person-centred nursing framework (McCormack & McCance 2010), it is not presented as a disjointed multidimensional model, but as an integrated interpretative one that values the identity of the older person and acknowledges the importance of life experiences. By working with the processes in the pillars using the elements of narrative being, narrative knowing and narrative doing, nurses can work in a storied way and ensure that person-centred outcomes and a narrative informed philosophy of care is achieved.

Limitations

There are some limitations to the framework. Working within the framework requires a systematic approach where nurses have to be aware of both their own values and beliefs and those of the older person. They also need to be willing to engage in 'knowing the being' of the person. Working in this way may be difficult for some nurses within the confines of everyday nursing practice and may require both cultural and attitudinal change where narrative is privileged and used. The framework is currently being implemented in practice as part of a larger action research study where its utility and effectiveness will be evaluated.

Conclusion

Care in residential care settings for older adults is moving away from the biomedical approach and adopting a more

person-centred focus. Providing services that are person-centred sometimes proves a challenge for staff. The usage of the framework of narrative practice can assist staff to overcome these challenges. It provides a guiding framework that identifies a set of pillars to inform a narrative approach and three operational elements, narrative being, narrative knowing and narrative doing, that make it possible for staff to confirm the identity of the older person by taking account of their past life experiences. The framework not only provides nurses and older people with a communication tool that can impact on the quality of care provided, but also ensures that that care is individualised and specific to the person. This framework also provides numerous opportunities for further research related to narrative usage and implementation in care practices. This study therefore has implications for nursing practice, policy development and research.

Relevance to clinical practice

First, this framework is intended to assist nurses with the operationalisation of person-centred narrative practice. To date, narrative approaches have focused on either using stories to describe patient experiences or as a method of reminiscence therapy. What has not been done to date is using narrative within the structure of a framework to enable nurses to provide care that is person-centred and individualistic. In practical terms, the framework outlines an approach that provides staff with a template on how to provide person-centred care in a narrative way. Second,

while the framework has been developed in an older adult care setting, it can be applied to any care setting where person-centred approaches are valued. Finally, it is not intended that the framework be prescriptive, but that nurses use the framework to critically examine how person-centred care is realised. By doing so, they can develop new ways of working that value biography and promote the development of a co-constructed plan of care that supports interaction and acknowledges the importance of life experience.

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Conflict of interest

We declare no conflict of interest.

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Appendix 14 Prompts for Interviewing Residents and Relatives

Interviewing a resident

Key questions.

1. **Start by using an opening question such as How are you today?**
2. **What is it like to live here?**
3. **What was your life like when you were younger? Can you tell me more about your younger days.**
4. **How do you spend your days now? Can you describe a typical day to me?**
5. **Do you have any ideas for improvement to this unit?**
6. **Do you have any ideas for improving your care?**
7. **Is there anything from your life prior to admission here that you would like to be still doing now? How could we help you to continue doing that?**
8. **Is there anything else you would like to tell me about your life here or your life before you came here?**

Interviewing a relative/friend/significant other .

Key Questions

1. **Start by using an opening question such as How are you feeling today?**
2. **What is it like for you visiting here?**
3. **Can you tell me anything about the interests of your relative/friend before they came in here?**
4. **What was a typical day like for them when they were younger?**
5. **What is your most significant memory of your (insert name of relative/friend) ?**
6. **Do you have any ideas for improvement to this unit?**
7. **Do you have any ideas for improving the care of your (insert name of relative/friend) ?**
8. **Is there anything from their past life that you think they would like to continue to do now? How do you think we could help them to continue to do that?**
9. **Is there anything else you would like to tell me about (insert name of relative/friend)'s life before they came here.**

Appendix 15

Workplace Culture Observation Proforma

Observation Area 1: Physical Environment

Observer Prompts	Observation Notes	Questions Arising
<ul style="list-style-type: none"> • What impression do you get from looking at the setting? <i>(You should consider various areas within the ward/department, for example patient rooms, nurses station etc)</i> • What do you see, hear and smell <i>(consider noise levels, lighting, dominating smells and activities that appear to shape the culture)</i> • Are call bells answered promptly? • Who does the environment privilege? Consider how patient friendly it is, or how staff friendly it is? Are there forbidden patient areas? Is there adequate seating for visitors etc?) • How is space used / furniture arranged / layout? (For example are chairs placed convenient and ready for use when staff are communicating with patients; also consider equipment location. Is the space cluttered? Are lockers and bedside tables clean and tidy? Is there space for visitors to sit and be with the patient?) • Who takes responsibility for the environment? • Does the physical environment reflect aspects of the residents past life (for example are pictures of past life/ hobbies/job displayed in the residents private space) • Does the physical environment reflect the current life of the resident (pictures or activities that reflect the current community the resident is in). • Is there evidence of the resident being involved in the day to day operation of the facility. 		

Cultural Observation Tool – Adapted to incorporate Narrative Aspects of Care (Shown in red)

Observation 2 Communication

Observer Prompts	Observation Notes	Questions Arising
<ul style="list-style-type: none"> • When and where does communication take place? • Who communicates with whom? <i>(Include staff-patient, staff-staff etc identifying professional type)</i> • How effective is nursing hand-over? <i>(Pay attention to the quality and type of information handed over, as well as to the focus of the report, its location etc</i> <i>Does the information integrate knowledge of the residents past life, identity and life status with aspects of their present care)</i> • What type of language is used? <i>(This refers to staff communicating generally as well as during nursing hand-over, is the language used patient centred, biomedical, or industrial type language more associated with production lines?)</i> • How are patients talked about? <i>(Include all professionals – see note above Is the residents previous life status reflected in the way they are talked about)</i> • How do staff refer to each other? <i>(Include all professionals – with respect/distain etc?)</i> • How do staff engage with each other? <i>(consider tone of voice, pace, pitch of voice; consider how different staff participate/don't participate in ward rounds)</i> • <i>How does the communication take account of the identity of the resident? (Consider how interactions occur between residents and carers does this locate the person in their present but also take account of their past life story).</i> 		

Cultural Observation Tool – Adapted to incorporate Narrative Aspects of Care (Shown in red)

<p>How are the expectations of the resident regarding their care acknowledged by staff?</p> <p>Is there evidence of communication and a sense of knowing one another between the resident and other residents and between residents and staff. (consider how this is reflected in the interactions taking place on the unit</p> <p>Are issues or concerns that the resident may have acknowledged in the communication?</p> <p>What messages does staff body language convey? (<i>Between staff, between staff and patients</i>)</p> <p>Are visitors made to feel welcome? (<i>how Are they greeted and treated?</i>)</p> <p>What tools are used to enable communication? (<i>Here you should note the various systems in use, written documentation, computers, whiteboards etc Do the tools used capture the life and story of the resident? In what way does this occur?</i>)</p> <p>What importance is placed on the tools of communication? (<i>Here you should consider the attention that is paid to the various communication means</i>)</p> <p>Is confidentiality respected?</p> <p>Do staff have meaningful engagement with patients or fleeting/task oriented conversations?</p>		
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Cultural Observation Tool – Adapted to incorporate Narrative Aspects of Care (Shown in red)

Observation Area 3: PRIVACY & DIGNITY

Observer Prompts	Observation Notes	Questions Arising
<ul style="list-style-type: none"> • Is patient privacy respected during specific procedures? • How is the valuing of diversity demonstrated (<i>including attitudes and behaviour towards minority groups, e.g. black and minority ethnic communities</i>)? • Are individuals needs and choices ascertained and continuously reviewed? • How is the acceptability of personal contact (touch) identified with individual patients /clients? • How are the patient's /client's personal boundaries identified and respected and communicated to others? • How is clinical risk handled in relation to complete privacy? • Note how privacy is effectively <i>maintained e.g. curtains, screens, walls, rooms, use of blankets, appropriate clothing, appropriate positioning of patient etc</i> • Note how privacy is achieved at times when the presence of others is required • Note how modesty is achieved for those in transit to differing care environments Are the staff aware of the resident's views on modesty? How is this demonstrated? • How are patients/clients views and needs ascertained and recorded? • Is information adapted to meet the needs of individual patients? 		

Cultural Observation Tool – Adapted to incorporate Narrative Aspects of Care (Shown in red)

Observation Area 4: PATIENT INVOLVEMENT

Observer Prompts	Observation Notes	Questions Arising
<ul style="list-style-type: none"> • Is there evidence of patients being able to make choices? • Do staff involve patients in planning and evaluating their care? • Do staff ensure that the history of the resident is acknowledged when planning their care? • • Do staff involve patients in making plans for their discharge from hospital? • Do staff have a rapport with patients? • <i>(General easy communication)</i> • Is there evidence of staff developing meaningful relationships with patients? • <i>(Note with whom)</i> • Is there evidence of patient education occurring as a part of everyday practice? 		

Cultural Observation Tool – Adapted to incorporate Narrative Aspects of Care (Shown in red)

Observation Area 5: TEAM EFFECTIVENESS

Observer Prompts	Observation Notes	Questions Arising
<ul style="list-style-type: none">• Do different staff groups have respect for each other?• Do staff work as a team?• Is there evidence of a hierarchy between and among staff?• Do staff have a clear sense of purpose?• Do staff freely question, challenge and support each other?• Is there evidence of staff initiating changes in practice?• Is decision making transparent, participative and democratic?• What style of leadership is in evidence?• Do the staffing levels seem appropriate to the workload in order to deliver quality patient care?• Is the skill-mix appropriate?• Is there praise and recognition for a job well done?		

Cultural Observation Tool – Adapted to incorporate Narrative Aspects of Care (Shown in red)

Observation Area 6: LEARNING CULTURE

Observer Prompts	Observation Notes	Questions Arising
<ul style="list-style-type: none"> • Is there evidence of resources for learning being available (<i>consider evidence of staff having access to computer, books, journals etc</i>) • Are opportunities for learning maximised? (<i>For example at hand-over or through reflective conversations during daily activity etc</i>) • Is there evidence of a staff performance development/appraisal system in place? • Are policy and practice guidelines used to inform practice decisions? • Are there mechanism for formal learning? (<i>Study leave, induction programmes, mentorship, etc</i>) • What kind of learning is privileged – e.g. technical skills or holistic practice knowledge? • Is there evidence of critical reflection happening (<i>consider evidence of critical questioning between staff; action learning, critical companionship; clinical supervision; workplace coaching</i>). • Do staff engage patients/families in learning about their illness/health and social care needs and approaches to self or assisted care? • Do staff utilise knowledge gained from general conversations with residents to plan and implement care? • 		

Cultural Observation Tool – Adapted to incorporate Narrative Aspects of Care (Shown in red)

Observation Area 7: RISK AND SAFETY

Observer Prompts	Observation Notes	Questions Arising
<ul style="list-style-type: none"> • Is equipment, used, maintained and monitored appropriately? • Are patients able to gain staff attention when needed? (<i>buzzers being attended to etc</i>) • Are assessments of risk used and acted upon? • Are the levels of risk taken appropriate to the practice context? • Is hand washing consistent with accepted standards? • Are open medicine trolleys left unattended? • Do staff check patients' armbands when administering medicines? • Are appropriate procedures for the handling and removal of used laundry in place? • Are bathroom areas maintained appropriately? • Is the environment free from risk? • How are the attitudes of the resident to risk and safety acknowledged 		

Cultural Observation Tool – Adapted to incorporate Narrative Aspects of Care (Shown in red)

Observation area 8: ORGANISATION OF CARE

Observer Prompts	Observation Notes	Questions Arising
<ul style="list-style-type: none"> Is the organisation of care patient centred and narrative orientated ? (Consider how aspects of the residents being and knowing are utilised in narrative doing with the resident). Do patients have an individualised plan of care (including discharge plan)?(Does the plan of care take account of the identity and selfhood of the resident? In what way?) Do nurses demonstrate care for patients? <i>Make note of how they do (or do not)</i> Is the system of nursing hand-over consistent with the method of organising care? Is care delivered consistently ? (<i>Here you should check if nurses, irrespective of what shift, deliver care <u>consistently</u> to individual patients, for example by paying attention to the care plan etc</i>) Are nurses visible in patient areas? Do nurses demonstrate responsibility for practice? (<i>here you are looking to see follow through, active communication, checking mechanisms etc</i>) Are meal times given priority? Are patients who need help with eating and drinking given the appropriate help? Is off duty planned around the needs of patients? Are patients content with visiting arrangements? Is all activity(actions) meaningful, does it have a purpose and provide an outcome for the resident? Is there evidence of reflective practice informing decisions around the organisation of care. Are residents involved in the everyday operation of the unit? How is this demonstrated? Are unusual activities (actions) such as grieving, bereavement incorporated into the organisation of care? (consider how this is demonstrated, make note of how staff do or do not acknowledge these activities and how they inform care). 		

Appendix 16 Action Plan Example Unit 1

Communication Action Plan

What do we want to achieve?

Effective/timely communication with staff, residents and relatives/friends.

What parts of the framework does this link with?

This links with narrative being and narrative knowing and will affect narrative doing.

What do we need to do to achieve that?

?? protected time.

Ensuring people feel confident/supported to meet with family members.

More informal meetings

Peer support

Integration of life story work with care plan

Communication tools –ward diary. Policy folders, verbal handover. Careplanning.

Do we need any additional resources? If so what are they and how can we get them?

Additional Practice Development input would help

Do we need to involve anyone else in this?

Practice Development dept.

How long will it take? (timeframe)

All staff to identify communication needs by mid February.

To also look at and identify communication needs of residents and relatives/friends.

Appendix 17 Action Plan Example Unit 2

Having More going on for/with the resident Action Plan

What do we want to achieve?

More meaningful interactions going on for and with the resident.

What parts of the framework does this link with?

This adheres to all parts of the framework as it addresses communication, knowing the person and engaging in a meaningful way.

What do we need to do to achieve that?

- a. Good communication between, staff, resident, families, significant others, activities coordinators.
- b. allocate/restructure day (how time is spent)
- c. Inform resident to ensure they are willing and encourage them to participate,
- d. Give choices/ asking what they want.
- e. encouraging more able bodied residents to start an activity when we are otherwise occupied.
- f. Ensure that all interactions are meaningful interactions
- g. Ensure that all staff know and respect what we are doing.

Do we need any additional resources? If so what are they and how can we get them?

- a. More back up service would be nice so that if the nurse is called away there is someone to take over, this can be a volunteer or family member. While this is good it is not necessary to achieve most of what is listed above. A lot can be done without any extra input.

Do we need to involve anyone else in this?

Activities nurse/ residents/ families/ significant others.

How long will it take? (timeframe)

Unsure yet but will set up an informal ward meeting next week to discuss with all staff to get their input and ideas. Would hope to implement within 1-2 months. Informal ward meeting week beginning June 10th.

Appendix 18 My Day My Way Example

I would like to share with you what is important to me when caring for me.

Name:

Room:

What makes me Happy ?



What makes me Unhappy?



Appendix 19 Prompts to Promote Writing in a Narrative Way



1. Write from the perspective of the person. Record their feelings, beliefs, desires as opposed to those of the carer.

Example:

John said "I'm a little tired today, I think I'll stay in bed"



As opposed to:

I noticed John looked tired today so I gave him a day in bed.

2. Write what the resident actually said in their own words. Also document any actions taken in response to this and ensure that any problems stated are re-evaluated.



Example

At 19.30 John complained of pain in his right leg. Stated: "the pain has come back in my right leg, it isn't too bad" John rated the pain at a 4 on a scale of 1-10. 2 panadol were given to John as per plan of care. Night staff to review effectiveness of pain relief.

3. Document conversations that centre around how the resident would like their day to go. Ensure that residents feelings and demeanour after activities/visits or trips are recorded.

Example

Mary and I discussed what she would like to do today. Mary stated: "I think I'd like to go to the activities inward this morning at 10".....

Mary returned from shopping trip at 16.30 said "had a great time bought a nice scarf can't wait to go out on the next trip".....



Other helpful ways to increase narrative interaction and help with narrative documentation.

- Ensure activities that residents takes part in match their stated interests.
- Integrate discussions about life-story into daily activities.
- Use photos if available to promote interaction.
- Be mindful that you are writing about a person
- Give the resident time – sit and chat if need be.
- Know when not to write in a narrative way eg. For clinical decisions when person is very ill or for the recording of TPR etc.

